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Clinical Lectures

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BY

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LECTURE IV.

ON THE DIAGNOSIS OF TUMOURS OF THE BREAST.

GENTLEMEN,—In my lecture last week, I brought under your observation the subject of the diagnosis of various forms of abscess of the female breast from cancer of that organ; and to-day I shall continue the same subject in connection with cystic and adenoid tumours.

These cystic growths, though not so common as cancer and the other solid tumours, are yet of by no means infrequent occurrence. They are of three distinct kinds:—1. Those in which the tumour consists of a single unilocular cyst; 2. Those which consist of several independent cysts aggregated together into one tumour—multilocular cysts; 3. Those in which a series of small cysts are diffused through a fibrous or hypertrophied mass; in fact, a combination of cysts with a chronic mammary tumour. Two theories are in vogue as to the origin of this form of cystic development. According to one set of pathologists, it is produced by the obstruction and subsequent dilatation of a lacteal duct. But this theory, I think, is weak: from the fact of our not being able to trace one of these ducts into the cyst; from the fact that the fluid contained in these cysts shows no trace of lacteal origin; and from the fact that such cysts are met with elsewhere, in places where no lacteal duct previously existed. The other theory is, that these cysts are entirely new formations; and this, partly for the reasons before mentioned, and partly because these cysts closely resemble those met with in other secretory glands, both as to structure and contents, appears to me to be the more tenable of the two.

These tumours, I must premise, whether unilocular, multilocular, or consisting of cysts diffused in a mass of fibrous or hypertrophied gland-tissue, are always composed of thin walls, formed of condensed cellular tissue, and containing in their interior a fluid variable in amount and character; being in one serous, in another glairy, in a third bloody; it is very commonly of a light straw colour, not unfrequently it is brown, and sometimes sanguineous, but these differences are accidental and of no importance.

We will now consider the diagnosis of these cystic growths from cancerous and other solid tumours of the breast. And, first, with regard to the unilocular cyst: this is the most common form, and occurs generally in women at what one might call the "cancerous age," viz., forty-five to fifty; it is frequently referred to pressure, or to a blow on the part, or it may be connected with uterine disturbance at the period of the cessation of the menses. Thus so far as the age and proximate cause are concerned, the history throws comparatively little light on the subject, and the diagnosis has therefore to be made entirely by palpation and examination of the tumour. Now you can easily conceive that, depending only on manipulation to form a correct judgment of the nature of the tumour, the surgeon may be exceedingly liable to form an erroneous opinion. I could relate to you many cases in which error of diagnosis has occurred, but I will confine myself to a few of the more illustrative.

I was requested some time ago, by my friend, Mr. Walter Wilson, to see a married lady, aged 45, who had in the right breast a tumour of about the size of an apple, hard and painful on pressure. This, she said, had been diagnosed as a fibrous tumour by a surgeon in the country, who had recommended her to come to London and have it removed. On examining the tumour, I suspected it to be a cyst. It had not the stony hardness of a solid tumour, but felt obscurely elastic on deep pressure. Acting on this supposition, I introduced an exploring trocar and let out about two ounces of dark serous fluid; the cyst never refilled, and the patient went home perfectly cured.

I was requested one day to see an unmarried lady, aged 44. On going to the house, I found her bathed in tears, and her sisters in great distress around her. I was told she had a tumour of the breast, which had been pronounced to be a cancer. On examination, I found a tumour in the right mamma, about as large as a pigeon's egg. It had been noticed about fourteen months previously, and the patient had been under both medical and surgical treatment for it. It was rounded, circumscribed, situated at the outer and upper part of the gland, hard but smooth, and not heavy to the feel. On close manipulation, I felt some elasticity. I told the patient that I did not think it was a cancer, but a cyst, and that if I punctured it and drew off the fluid contained within it she would probably have no further trouble. She then informed me that she had seen an eminent surgeon, who had pronounced it to be cancer; had explained that an operation was necessary; that the whole of the breast must be removed, and had fixed an early day for its performance. I requested to meet this gentleman, but this was refused by the patient and her friends; and as the opinions expressed differed so widely, it was agreed that she should have the benefit of Sir B. Brodie's opinion. That distinguished surgeon saw the case with me the next day, and, he having acquiesced in the opinion I had expressed, I tapped the cyst, and let out about an ounce and a half of yellowish serous fluid. The tumour collapsed, all idea of operation was abandoned, and the patient has continued well up to the present time.

I saw the other day a very similar case. It was that of an unmarried lady, aged 48, who had had for about twelve months a tumour in the left breast, which had gradually increased in size, until it had attained about the magnitude of a Tangerine orange. It was hard, circumscribed, situated at the axillary border of the gland; it had also been pronounced to be scirrhus. But, suspecting from its elasticity that it was cystic, I punctured it with an exploring trocar, and drew off about ten drachms of clear fluid, causing the immediate subsidence of the tumour.

Now here were three cases of simple cystic or fluid tumour of the breast, which had erroneously been pronounced to be solid, and which would have been submitted to amputation of the mamma if the mistake had not been discovered in time. It is of very great consequence, therefore, to be cautious in these cases in pronouncing a definite opinion, and to neglect no means in perfecting your diagnosis. How is this to be done? As I have already stated, the history very often throws no light on the nature of these cases. Cysts occur at the same age and among the same class of people as cancer of the breast, but there is one circumstance of great importance to which you must always attend, and that is the presence or absence of *elasticity*. This last character may be said to be the great diagnostic point between these tumours and cancer; and whenever you feel, or even suspect, elasticity, you ought to introduce an exploring trocar. If the tumour is cystic, the fluid escapes, and you probably hear no more of the case. But if, on the contrary, it is solid, a drop or two of blood only oozes out, the puncture soon closes, and no harm is done. In making this puncture, there is one little point to be attended to, and that is, if you use an exploring needle, take care to push it straight in, and not to make the puncture in any way valvular; for if you do, the fluid may not escape, and thus a serious mistake may arise; it is, however, far better in all cases to use the exploring trocar in preference to the grooved needle.

If this little operation—tapping—does not procure the closure of the cyst, you must resort to other measures, such as injecting it with iodine, introducing a seton, or, if these fail, excision of a piece of the cyst-wall. But you will generally find that tapping and the subsequent use of iodine lotions will suffice to effect a cure.

The next kind of cyst—the *multilocular*—is more difficult to diagnose than the unilocular; firstly, because it is generally seated deeply in or beneath the gland, while the unilocular occurs chiefly at the border or anterior surface, and because there is not so much fluctuation, owing to the fluid being divided among several cysts. But yet there is that never failing sign of cystic disease,—elasticity. You will find, however, that there often exists a good deal of condensed fibrous matter round about these tumours, and hence the removal of the whole gland may be required, the extirpation of the cysts alone being impossible. One reason why cyst-tumours are often so difficult to diagnose as such, is that they are often associated with cancer. There great difficulty exists, especially in the early stage; and these cases are exceedingly liable to be confounded with cystic sarcoma, and indeed in some cases you cannot make your diagnosis until the tumour is removed, and then only by a careful microscopic examination.

A woman, aged 45, was admitted into this hospital with a tumour of the size of an orange, situated in the right mamma deeply over the pectoral muscle. It had existed for about five years, was not adherent to the skin, and there were several cysts of the size of plums. At the upper part of the mass, which could be felt through the lately mucous covering, the nipple was not retracted; there was only one slightly enlarged gland in the axilla. Now, here were all the characters of a "cystic sarcoma"—slow growth, no adhesions, cysts, and no material glandular implication; and yet, after the removal of the breast, the microscope revealed the tumour to be distinctly and decidedly cancerous.

You will sometimes find that tumours of a mixed, possibly a semimalignant character, occur with cysts, and give rise to great difficulty in the diagnosis of their exact nature, and render it impossible for you to pronounce with certainty whether they are benign or malignant. The following is a case of this kind.

An unmarried lady, 40 years of age, and in excellent health, was sent up to me by my friend Mr. Tuxford of Boston, last November, with a tumour of the right breast, which, without assignable cause, had commenced growing about five years and a half ago; it increased slowly until it had attained the size of an orange about two years since, but afterwards much more rapidly, until at last it reached the size of an adult's head. The skin covering it was not reddened, and, though thinned, was neither adherent nor infiltrated. There was no pain at night, or after handling it; and no enlarged glands could be felt in its neighbourhood. The superficial veins were much enlarged over the tumour, and a good sized artery was felt to pulsate over its upper part. It was elastic, lobulated; and a large mass, of a cystic character, projected from its anterior surface. There were no adhesions between it and the pectorals, or to the skin. The operation was performed on November 10th. On removal, I found that the tumour weighed ninety-six ounces, and consisted of large encapsuled masses, of a dull grey or brown colour. On section, it was solid in parts, and infiltrated with a gelatinous fluid; in others, there were large cysts, containing several ounces each of dark stringy mucoid fluid. Dr. Harley, who examined it, pronounced it to be colloid. There were also masses of fibroplastic deposit in some parts.

Now here was a case that approached closely to malignancy in its local characteristics, without any constitutional symptoms of cachexy; and which presents an appearance on examination that renders it doubtful whether it may or may not yet recur.

The next class of cases to which I would direct your attention are the chronic mammary or adenoid tumours. These are of exceedingly common occurrence; and there are two or three conditions with which they are often associated, the knowledge of which materially assists the surgeon in his diagnosis. 1. With regard to the age, they generally occur before the cancerous age, in early womanhood, between the ages of 18 and 25. 2. They are almost invariably slow in their progress. 3. They are lobulated, distinct, non-adherent to the skin or pectorals, and circumscribed. 4. There is no cachexy or glandular enlargement; and, in fact, they appear to be quite local and benign. There is usually no cause to which they can be assigned; but I believe that they frequently occur in young women of nervous temperament, and are commonly associated with uterine disturbance of some kind. The chief diagnostic points are, therefore, the age of the patient, the slowness of growth of the tumour, and the perfect freedom from constitutional symptoms; but yet any one of these conditions may be present in cases of undoubted cancer of the mamma.

Scirrhus very rarely occurs at the early period at which the adenoid tumour is common; but yet it is occasionally met with in young women. Some years ago, I removed in this hospital a tumour from the right breast of an unmarried female aged 23. It was as large as a small flattened orange, was hard, nodulated, but not adherent to the skin. There was no retraction of the nipple, and it had been growing for about eight months. No cause could be assigned for its appearance, and it was supposed to be adenoid. However, on account of the large size of the tumour, as compared with that of the somewhat atrophied mamma, I removed the whole of the breast, together with the tumour; and it was well that I did so; for, on microscopic examination, it was found to be scirrhus. The patient subsequently married; and when I last heard of her, two years after the operation, she was in good health. Now, here is a case in which cancer occurred within the period usually assigned to chronic mammary tumour; and hence you cannot rely altogether on the age of the patient as a means of diagnosis.

Next, with regard to the slowness of growth: although it is an undeniable fact that benign tumours usually grow slowly, and that rapidity of growth is generally a sign of malignancy of action, yet this rule must also be taken with exceptions, as in the following case.

Last June, I was requested to see an unmarried lady, aged 40, of a nervous sanguineous temperament, who had been in bad health for many years, suffering from uterine disturbance, dyspepsia, and latterly from pulmonary symptoms. At the age of 18—that is, twenty-two years previous to my advice being sought—she noticed for the first time a small tumour in her left breast; this continued perfectly stationary, and about the size of a pigeon's egg, until last February, when it for the first time became painful, and began rapidly to enlarge. Being at this time in Italy for the benefit of her health, this lady saw two distinguished Roman surgeons, who, after careful examination and exploratory punctures, pronounced the tumour to be "myeloid", and recommended extirpation of the mamma. The patient, however, preferred to return to England, and have the operation performed here. On her way home, she saw Velpeau in Paris, who, with great accuracy of diagnosis, pronounced the tumour to be "benign", and gave her a written statement to that effect. When I saw her, on her return to this country, in June last, I found a tumour of the left mamma, perfectly mobile, firm, solid, and inelastic; it had attained the size of an adult's head, and it was rapidly increasing. There was no glandular enlargement in the axilla; the skin was thinned and reopened, but not adherent; the superficial vessels were much enlarged, a tortuous network of veins and one or two large arteries running over the tumour. There was no constitutional cachexy; but the patient's health and strength were at the lowest ebb, from general and long standing constitutional derangement; and she could not sleep at night, not so much from pain (which, however, was constant, and at times very severe), as from the constant anxiety of mind which the presence of the growth produced. Sir B. Brodie and Dr. Walshe, who saw the case in consultation with me, both agreed that it was probably benign, but that no operation was practicable until the patient's state of health was improved. However, by attention to diet, and by being put on a proper plan of treatment, this was so much ameliorated that, in July last, I was enabled, with the assistance of Mr. Marshall and Dr. Cowan of Glasgow, to perform the operation for its removal. This was attended by no difficulty, and by very little hæmorrhage, notwithstanding the size of the tumour, which weighed rather more than five pounds. The patient made an excellent recovery, and was able to leave town in less than three weeks. On examination after removal, the tumour was found to be lobulated on its surface. The section showed it to be homogeneous, and of a uniform greyish colour, with no soft points or cysts, but distinctly and firmly encephalous. Dr. Harley, who examined it microscopically, found it to be a specimen of the chronic mammary tumour of Sir Astley Cooper. In the plastic matter taken from different lobules, examples of the glandular tissue were found. Some of the blind tubes were remarkably distinct, and well filled with cells. There was no trace of cancer.

Now here was a tumour which, after remaining of small size and stationary for more than twenty years, suddenly, and without obvious cause, began rapidly to increase; so much so that, in less than six months, it had increased in size from that of a pigeon's egg to the magnitude of a mass weighing more than four pounds. Here was extreme rapidity of growth, without malignancy of character. In fact, this extreme rapidity of growth resembled rather what is not unfrequently found in encephaloid disease, than what we expect to meet with in the chronic mammary tumour, and rendered the diagnosis not a little difficult; the more so, as it was possible that the chronic mammary tumour, which had existed for so many years in a stationary and passive condition, might have suddenly undergone malignant degeneration, and thus taken on rapid increase of bulk. This, however, was disproved by the careful microscopical examination made by Dr. Harley, who found that the tumour did not present a trace of malignant structure.

It is, however, important to bear in mind that cystic and adenoid tumours may remain for a long time in a benign and passive state, and then assume malignant characters. This happened in the case of a woman aged 48, who was sent to the hospital by my friend Mr. Adams two years ago. At the age of 27, she had first observed a tumour in the left breast. This had slowly increased in size, until it had attained, at the end of fifteen or sixteen years, the size of the fœtal head. When I first saw it, in January 1858, it presented the appearance here depicted. (Fig. 1.) One of the cysts of which it was com-

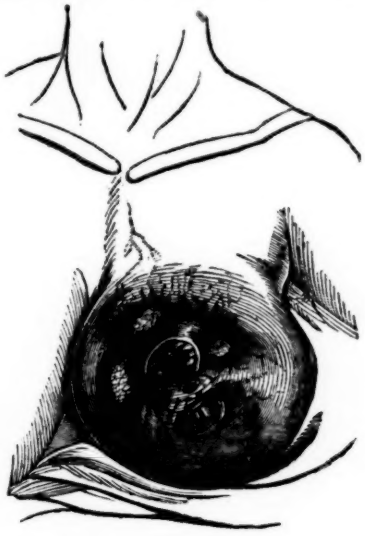

Fig. 1.

posed had ulcerated, and a thin sero-sanguineous discharge oozed out of the opening. The general health was good. There was no glandular enlargement in the axilla, or adhesions of the skin, except around the ulcerated parts. It was freely moveable on the pectorals. An operation for the removal of the tumour was proposed, but this the patient refused to consent to. At the end of six months, she returned with a large ulcerated cavity in the centre of the tumour, and fungating masses sprouting from the bottom of it. (Fig. 2.) There was still no cachexia, or enlarged glands in the axilla. The patient now consenting to an operation, I extirpated the whole mass with the mamma. On examining the tumour after its removal, it was found to be cystic. There were several large cysts, of the size of pigeons' eggs, containing turbid but light coloured serous fluid. The central portion of the tumour, and that at the base of the fungus, were solid, grey, and rapidly undergoing softening and disintegration. On squeezing this portion of the mass (the base of the fungus), a milky juice exuded; and Dr. Harley, who examined the tumour, stated it to be encephaloid. The sarcomatous structure beyond this, constituting the general mass of the tumour, appeared to be adenoid. The surface of the fungus, when exposed and protruding beyond the cyst, was epitheliomatous.

Now here were cystic sarcoma, encephaloid, and epithelioma, associated in one growth. The encephaloid was stated by Dr. Harley to be cellular, without fibres, shewing rapid development. The epithelioma was confined to the surface of the fungus. The history of this case, the very lengthened period (more than twenty years) that the tumour had existed, the absence of all constitutional cachexy, of deep adhesions, or

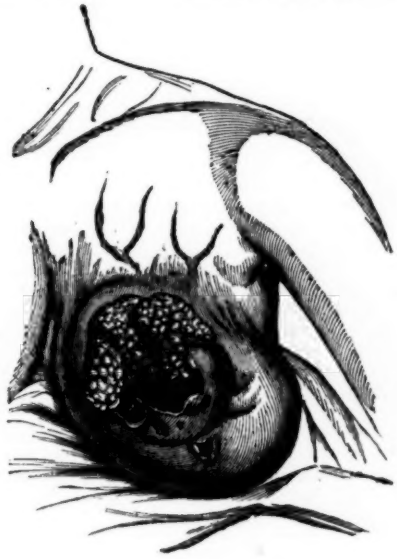

Fig. 2.

of glandular enlargement or other secondary deposits, and its appearance only six months previous to removal (Fig 1.), all pointed to primary simple cystic disease of the mamma, in which, as the result of secondary changes, encephaloid had developed itself; being an instance of the conversion of a simple into a cancerous tumour of the breast. This patient died about a twelvemonth after the operation, of gangrene of the foot and disease of the heart. The cicatrix was quite sound; but in the substance of one of the ventricles a nodule was found, which was considered by those who examined it to be of a cancerous nature.

Academy of Sciences. At the last sitting a commission was appointed, composed of MM. Velpeau, Rayer, J. Cloquet, Andral, and Cl. Bernard, for the purpose of awarding the Barbier prize. This will be the first time of its being adjudged; and as it is intended as a reward for any great discovery in surgery, medicine, pharmacy, or medical botany, there will be several candidates in the field; and we need only remind our readers that, in the course of a few months only, hipnotism, coal tar plaster, the regeneration of bone, the cure of lockjaw, and santonine applied to amaurosis, have been in the field, to convince them that the conflict will be a severe one. M. Boutigny, in a note, endeavoured to show that the expression commonly used of the spheroidal state of liquids was erroneous, and calculated to give a false iden of the molecular state of matter. He observes that it is by no means necessary that a body should be in a liquid state in order to assume the spheroidal one; and that he has made chloride and nitrate of ammonia, the bichloride of mercury, camphor, iodine, stearic acid, wax, tallow, etc., pass directly from the molecular to the spheroidal state. He more especially calls the attention of the Academy to a curious fact in corroboration of his theory—viz., that if small pieces of ice, of the weight of a few *grammes* only, be operated upon, and they be thrown on the back of the hand, partly in a liquid and partly in a solid state, two different sensations will be felt in a very short time; first, a strong heat (98° centigr., 208° Fahr.), and afterwards an equally strong sensation of cold (freezing point). M. Prou sent in a paper on the possibility of suppressing switchmen on railways by introducing a self-acting lever, by means of which the engine driver himself may have the switches under his command. The Academy received a paper from a competitor for the Bréant legacy. He is a physician in the island of Java, but has concealed his name under a sealed cover. His remedy for cholera, and which he states to have always succeeded, is liquid ammonia in sugar and water, aromatised by a few drops of essence of peppermint. (*Galignani.*)

Lectures
ON
THE HISTORY OF MEDICINE.

DELIVERED AT
THE GROSVENOR PLACE SCHOOL OF MEDICINE.

BY

ALEXANDER HENRY, M.D.

LECTURE II.

Origin of Medicine. Difficulties of its Investigation. General Characters of the Early Stages of Medicine. Medical System of the Ancient Egyptians. Grecian Legends. Apollo. The Cabiri. Orpheus. Incantations. Melampus. Chiron. Heroes of the Homeric Poems. Æsculapius: Examination of the Myth concerning him. Machaon and Podalirius. The Æsculapian Temples and Symbols. Practice of the Asclepiads. Summary.

[Continued from page 264.]

AFTER the preceding notice of the state of medicine in ancient Egypt, I will pass on to examine the history of the science in Greece, and to exhibit its development in that country. The most interesting part will be that which commences with the Asclepiads; but, anterior to this period, there are, among the mythological fables and poetic narratives, a series of facts relating to medicine which I will place before you.

First, then, we have the notion of the immediately divine origin of disease and of medicine prominently standing forward. You are, doubtless, familiar with the opening scene in the Iliad, where Apollo, excited to anger, induces a plague in the Grecian army. Apollo was, at a subsequent period of Grecian mythology, regarded as the god of medicine, and more or less confounded with Pæon. In Homer, however, Παιων, the physician of the gods, is a distinct personage. Diana and Eilithyia also are important medicine-deities in the Grecian mythology. But let us turn from gods to men, and examine what is to be found relative to medicine in the Hellenic legends down to the period of the destruction of Troy.

In the most ancient Grecian records, we are introduced to a number of personages, and probably families, to whom a knowledge of medicine is attributed; and, in regard to several of these, tradition and etymology point to the east as their origin. Foremost in the mist of fable appear the Cabiri and Curetes, introducing from Asia, with mystic rites, a certain comparative amount of civilisation among the barbarous inhabitants of Greece; and therewith introducing medicine as part of a religious system. Then, dating back to uncertain periods, ranging from the twelfth to the fourteenth centuries before the Christian era, we find certain individuals, or probably families of priests known by a common name, who are celebrated as the possessors of knowledge beyond their fellows, and the disseminators of further civilisation. Such are Orpheus the Thracian, Melampus the Argive, and Bacis the Athenian or Bœotian.

Orpheus, with the fables relating to whose musical skill you are no doubt well acquainted, is one of the earliest with whose name medicine is connected. But beyond his general reputation as one of the founders of the science, we have no direct knowledge of his contribution. The myth of the miraculous effects produced by his lyre has possibly, in certain points, a reference to the beneficial effects of music in some diseased states having been recognised by him, or by the priests of the order of which Orpheus is accepted as the personation. In connection with him, there is a remarkable tale, which probably points to his skill in the treatment of disease. I mean the fable of his obtaining permission from Pluto, having overcome him by his music, to bring back his wife Eurydice from Hades—a permission which was, however, the legend says, clogged with a condition which Orpheus found himself unable to fulfil. And, while we have before our notice the traditions relating to the musical powers of Orpheus, it may be suggested that these traditions have a connection with the use of charms; of the kind, I mean, which is mentioned by Homer when he says of Ulysses, in the Odyssey, that, on one occasion when he had been wounded in the thigh by the tusk of a wild boar, his friends "staunched the black blood with a charm"—ἐπαοιδῃ in the original, or *carmen*. The practice of employing charms or ἐπαοιδαι for the relief of disease probably originated in the prayers, often in music, to the gods, which either the priests offered, or caused to be offered by the patients who frequented the temples; and the people, seeing the relief which followed the use of these, would assign them as the remedial measures.

Melampus is by some said to have been anterior to Orpheus. He is reputed to have been an Argive shepherd; and a most remarkable tale is related of him in connection with medicine, which, if it be true (and I think there is some truth in it) would show an exercise of acute observation in the person of whom it is narrated, and a greater insight into the treatment of disease than we find noticed for several subsequent ages. The fable runs, that the three daughters of Prœtus, king of Argos, were struck with insanity for insulting the statue of Juno. A fragment of Hesiod describes their malady in such a form as to leave no doubt of its having been lepra—"Their head was covered with frightful crusts; their hair fell off in several places; and their whole skin was covered with lenticular spots." The myth regarding them states that they imagined themselves turned into cows, and made the valleys resound with the cries they uttered in imitation of those animals. Their insanity was communicated to other Argive females, who left their families to wander in the woods with the Prœtides.

Sprengel explains the fable by stating that delirium is a frequent consequence of leprosy; that the voice of persons so affected becomes changed, so as to sometimes resemble that of animals; that certain forms of mania are readily communicated; and that the pretended metamorphosis into cows was derived from the rural habits of the Arcadians. Melampus, it is said, effected the cure of these ladies by natural means, the use of which does honour to his penetration, although he was obliged to employ mystery. Observing that his goats were purged as often as they ate hellebore, he fed them with it, and gave their milk to the daughters of Prœtus. Other accounts state, that he employed a number of strong young men to chase them over a distance of about ten leagues; an exercise which, Sprengel supposes, must have been very efficacious in bringing about cutaneous transpiration. After this, he caused them to bathe in the river Anigrus.

Whatever there is of fable in this history, we must take it as the account of a remarkable application of medical knowledge; and as one of the earliest—if not the earliest—recorded instances of a cure being effected by the use of active remedies affecting the system in general. That it was the only one, or the first of its kind, we cannot say; for, as I have already hinted, the actual treatment of disease was too much veiled in the mysteries of priesthood to be intelligible to us.

Besides the divinities and priests or prophets of ancient Grecian mythology, many of the heroes and heroines enjoyed a reputation for medical knowledge. Foremost among these stands Chiron the Centaur, probably a Thessalian chief, the reputed instructor of many heroes in the arts of music, legislation, astronomy, hunting, and medicine. Among his disciples are reckoned Æsculapius, Amphiaraus, Nestor, Peleus, Telamon, Meleager, Theseus, Hippolytus, Palamedes, Achilles, Ulysses, Menestheus, Diomedes, Castor, Pollux, Machaon, Podalirius, Antilochus, Æneas, Achilles, Aristæus, and Jason. He is said to have been very successful in the treatment of diseases; and, among other actions, to have cured Phenix, the son of Amyntor, of a blindness supposed to have been incurable. His skill, however, would seem to have failed in his own case; for his death is attributed to a wound inflicted by Hercules with an arrow dipped in the blood of the Lernean hydra. This event became commemorated in after ages, by the application of the term *Chironian* to malignant ulcers, and of the name *chironia* or *centaurium* to the plant from the use of which he is supposed to have sought relief. After his death, he received divine honours in some of the Grecian states.

In the Homeric poems, Achilles and his friend Patroclus are celebrated for their medical skill. In the eleventh book of the *Iliad*, Eurypylus, one of the Grecian heroes, having been wounded by an arrow in the thigh, thus addresses Patroclus:

"But save me; to the black ship lead me back;
And from my thigh cut out the dart, and wash
With water warm the black blood from the wound.
Then sprinkle on mild drugs, health-giving drugs,
Whose use, 'tis said, to thee Achilles taught,
Whom Chiron the most just of Centaurs taught.
For Podalirius, and Machaon too,

Can give no aid; Machaon, as I think,
Sore wounded lies among the tents, himself
Needing a good physician; on the plain
The other bides the sharp-contested fight.
* * * *
Patroclus said: then seizing by the breast
The people's shepherd, led him to his tent;
And the attendant, seeing them approach,
Spread for a couch shields made from of hides of bulls.
Stretching him there, Patroclus from his thigh
Cut with a knife the keenly pointed dart.
Then rubbing in his hands a bitter root,
He laid it on the wound—a soothing root,
Which eased his pains, and staunched the flow of blood."

This narrative gives a very good example of the kind and amount of skill which was attributed to the heroes of ancient Greece, those who are celebrated in connection especially with the Argonautic expedition and Trojan war. But, leaving these heroes, let us now turn our attention to the first traditional personage whose fame rests entirely on medicine, and not, like that of those to whom I have already referred, on deeds of war.

Æsculapius, or, as the Greeks called him, Asclepios (Ἀσκληπιος), was reputed to be the most famous, in regard to medicine, of the pupils of Chiron. He utterly eclipsed in medical fame all who had preceded him; and his name, down to the present day, is honoured in connection with the foundation of medicine as a science. Yet the accounts of him are so discrepant and irreconcileable except on one supposition, that I hesitate in accepting Æsculapius as a real historical personage. As to his birth, there are several traditions. According to some, he was the son of Coronis, a Thessalian princess, by the god Apollo, and was preserved in a miraculous way—either, as one fable relates, by being suckled by a she-goat, or, according to another, by being rescued by Mercury from the flames that were about to devour the body of Coronis, who had been slain by Apollo for faithlessness. Another tradition makes him the son of Arsinoë, a Messenian princess: this tradition, however, is less accepted than the former one. Æsculapius is also reckoned by Philo-Biblos as one of the Phenician Cabiri, to whom, as I have already stated, the introduction of arts into Greece is attributed. The Egyptians also claim him, according to Clement of Alexandria, making him a pupil of Apis.

How are these statements to be reconciled? Some have supposed, that there were several persons named Æsculapius; one of whom eclipsed in fame those of the same name. But I am inclined to apply to etymology, and to see whether there is anything in the name which may lead us to suppose that it was not the name of an individual, but an attribute of a class of men, dressed in Greek, and handed down as a proper name. Let me give one or two examples of what I mean. You are probably aware that the names "Darius" and "Pharaoh" are looked on not as proper names, but as titles. In some other instances, also, the application to historical or mythical personages, of names derived from some circumstance connected with them, is noticeable. Thus, Cadmus is said to have introduced letters from Phenicia into Greece: this myth means nothing more than that letters were introduced by immigrants from the east—for the word *kedem*, in Hebrew, which is allied to the Phenician language, means the east. Again, you have all doubtless read in Roman history of the capture and destruction of Rome by Brennus. In Celtic, the word *brenin* signifies king; and the name Brennus is probably nothing but a Latin corruption and appropriation of a title. Now let us take the word Asclepios. Numerous etymologies, Greek and Phenician, have been given. The Greek are fanciful and very unsatisfactory. Of the Phenician, there are one or two which appear more plausible; such as, *Is calaphot*, a man of the knife. Again, in the allied dialect—the Hebrew—*askel* means "understanding, skill"; and the latter part of the name seems referrible to a word allied to the more rare Hebrew vocable *abach* or *ibcha*, which some lexicographers translate as "the point of a weapon" (*cuspis, mucro*). At any rate, the etymology of the name Asclepios points to an eastern origin, from which the transition into a Grecised form was as easy as that from *kedem* into Cadmus.

Æsculapius, then, appears to have been a Phenician; but we have the difficulty of reconciling with this the fact of his sons being Thessalian princes. This last circumstance would give countenance to the existence of a Thessalian Asclepios. Possibly, the fact was this. A Phenician, or Phenician colonists of men, who had specially cultivated medicine, introduced a comparatively advanced state of the science into Greece. They were known, we may suppose, by some title denoting their professional skill: which title the Greeks, fashioning to their own language, would make into Asclepios. The name then, perhaps at first scarcely used as a proper so much as a generic term, might be applied to any one, a prince of Thessaly for instance, who should cultivate the healing art in a manner beyond others. In this way, by supposing Æsculapius to have been a generic term, we may understand how it is that several individuals have been classed under one name, until at last the knowledge which each gave to the world has been accumulated to the credit of one personage whom tradition hands down to us as Æsculapius, the god of medicine.

It may be objected that the deification of Æsculapius goes to prove his individuality. But it would not do so; and further, we have the negative evidence of Homer, who nowhere mentions Æsculapius as a god. For instance, in the fourth book of the *Iliad*, he calls Machaon the "son of Æsculapius the faultless physician". If Æsculapius was deified before the Trojan war, he could not have been the Thessalian of that name, the alleged father of Podalirius and Machaon.

The conclusions at which, I think, we may arrive regarding the personality of Æsculapius then are:

1. That the name Æsculapius is a general term, applied at first to some individual or class of individuals signalised by a special cultivation of medical art;

2. That the term, having been Grecised, was, before its acceptation as a proper name, applied as an epithet to several persons who were remarkable for the same cause as those whom it originally designated;

3. That there are in history several distinct persons having this name.

So great skill in medicine was attributed to one of the persons named Æsculapius, namely, to him who is fabled to have accompanied the Argonauts in their expedition, that he is said to have restored several of the heroes to life, and, in consequence, to have been killed with lightning by Jupiter, on the representation of Pluto that Hades would become depopulated. Heraclitus and Suidas say that he died of an inflammation in the chest. On this, Sprengel remarks that some forms of pulmonary gangrene are followed, after death, by a lividity of the body, which would give the idea of the person having been struck by lightning. The practice assigned to Æsculapius by the ancients consisted in the treatment of wounds and ulcers by the application of astringents and anodynes; the administration of medicinal and dietetic drinks; and the employment of charms or ἐπαοιδαι.

Machaon and Podalirius were the reputed sons of Æsculapius. I call them reputed sons; for it must remain an open question, whether they were really the sons of one of the celebrated medical personages to whom the name Æsculapius was given, or whether they were called sons of Æsculapius on account of their having devoted themselves to the special cultivation and practice of the art of healing. Homer represents them as at once warriors and "healers"; but places their medical character always prominently forward, while the medical skill of Achilles, Patroclus, and other heroes, comes in incidentally. In the second book of the *Iliad*, in the catalogue of ships, they are thus mentioned for the first time:

"And those who Tricca, and Ithome's hills
Inhabited, and who Œchalia held,
The city of Œchalian Eurytus,
Them Podalirius and Machaon led,
Sons of Asclepios, good physicians both;
And with them followed thirty hollow ships."

The application they made of their skill seems to have been much of the same character as that to which I have referred in the example of Patroclus. They were chieftains—"shepherds of the people" (ποιμενες λαων), as Homer calls them in common with other heroes; and were both brave in battle; and in connection with this, we derive from the Homeric poems an instance of the high repute in which the cultivators of medical art were held in ancient days. Let me quote, from the eleventh book of the *Iliad*, the passage which refers to this circumstance. A battle between the Greeks and Trojans is being related.

"The noble Greeks would not have given way,
But Paris, fair-haired Helen's spouse, restrained
Machaon, people's shepherd, from brave deeds,
With triple-barbed arrow wounding him
In his right shoulder: and forthwith the Greeks,
Yet breathing valour, trembled lest the foe
Should capture him amid the wavering fight.
And thus to godlike Nestor cried Idomeneus:

O Nestor, Neleus' son, the Achæans' pride,
Quick mount thy chariot; seated at thy side
Machaon with thee take; and swiftly drive
Thy horses to the ships; for in his worth,
To cut out arrows and apply mild drugs,
A good physician hosts of men excels."

Of the future history of these two medicine-heroes, after the fall of Troy, it is recorded that Machaon spent the remainder of his life in Messenia. Podalirius, after having suffered shipwreck, arrived at the court of Damætas, king of Caria, where he had an opportunity of exercising his skill on Syrna, the king's daughter, who had injured herself by a severe fall. At a time when her life was despaired of, he bled her in both arms, with a happy result. The king, in gratitude, gave Podalirius his daughter in marriage, and presented him with large territorial possessions in Caria. Whether this be myth or history, it is remarkable as the first *recorded* instance of venesection; although we can scarcely suppose but that this operation was previously known.

[*To be continued.*]

Illustrations
of
HOSPITAL PRACTICE:
METROPOLITAN AND PROVINCIAL.

HULL INFIRMARY.

FIVE CASES OF INJURY TO THE HEAD.

Case I. *Fall upon the Head: Probable Laceration of the Brain: Partial Recovery: Relapse: Death and Autopsy.* (Under the care of R. M. Craven, Esq.) Charles Edwards, aged 52, was admitted on July 24th, 1858, at 4.15 P.M., having fallen from the deck into the hold of a vessel, a distance of about twelve feet. He was much addicted to drink, and was supposed to be somewhat under the influence of it at the time of the accident. On admission, he was insensible; the pupils were dilated. There was a slight graze only on the vertex; no fracture was detected; and there was no discharge from the ears. Cold was applied to the head; the bowels were relieved freely at night; the urine was withdrawn by the catheter.

July 25th. He appears less drowsy, and takes notice when spoken to. A large blister was applied to the nape of the neck.

July 26. He is still rather drowsy; pulse feeble and slow. Two grains of calomel were ordered to be taken every two hours; and an enema of turpentine and castor was administered.

July 28th. The bowels have been well opened; he passes his urine naturally. There is congestion of the conjunctiva of the right eye. He was reported by the other patients to have had a fit, the right side being affected.

Aug. 1st. Considerable improvement has taken place in the last two days. He is quite conscious, and speaks when addressed. The gums are very sore. The calomel was omitted.

Aug. 5th. He has become more drowsy the last day or two, and sleeps a great deal. Pulse very feeble. The pupils are rather contracted, but sensible to stimulus. He was ordered to have an ounce of quinine mixture three times a day; to resume the calomel; and to have brandy in sago, etc.

Aug. 10th. The drowsiness and torpor have increased the last few days, so as to amount to complete coma. The pupils are much contracted. Respiration is puffing. The pulse is of moderate volume and frequency. Motion and sensibility are completely in abeyance. The head was ordered to be shaved, and a large blister to be applied to it.

Aug. 11th. He died at 12.30 this day, eighteen days from the date of the injury.

Autopsy, eight hours after death. On removing the calvarium, the dura mater covering the left hemisphere presented a dull greenish hue, and yielded to pressure more than on the right side; it had the aspect of commencing decomposition. It was firmly adherent to the brain along the median line, especially posteriorly; and, when reflected on the left side, it was found to be lined with a thickish layer of brownish coloured blood. The effusion was evidently not of recent date. This hemisphere appeared compressed, but was of the same consistence as the right. In the substance of the middle lobe on the left side, near the base, was a hollow cavity capable of holding a marble; it had apparently been filled with blood; and most probably from this spot the hæmorrhage arose in the first instance. The rest of the brain-substance was natural, there being no further laceration observable; nor was there any fracture of the skull. There was more fluid than natural in the ventricles. The layer of effused blood completely enclosed the left hemisphere, being in contact with it in every part.

Case II. *Compound Fracture of the Frontal Bone over the Frontal Sinuses: Recovery.* (Under the care of R. M. Craven, Esq.) Isaac Wakelin, aged 14, was admitted on October 16th, 1858, having fallen from the third story of a building upon a heap of bricks, his fall being partially broken by his coming in contact with a wooden beam in his descent. When picked up, he was insensible, but, on admission, perfectly conscious. There was a large gaping triangular wound immediately over the frontal sinuses, the outer wall of which was driven in upon the inner. In the wound were several small pieces of brick, but no detached portions of bone. There were no cerebral symptoms of any kind. Water dressing was applied. There was also a fracture of the lower end of the left ulna. He was ordered to have three grains of calomel at night, and an aperient draught in the morning.

Oct. 18th. He is very comfortable, but is reported to have had a fit in the night. He was ordered to have a grain of calomel and an effervescing saline draught every four hours.

Oct. 20th. No cerebral symptoms have shown themselves. The wound is discharging freely.

Nov. 10th. He was made an out-patient. The wound had quite healed by the end of the month, leaving a considerable depression in the forehead.

The nature and situation of the injury in this case justified a favourable prognosis, which was verified by the result.

Case III. *Fracture of the Skull: Slight and temporary Paralysis: Recovery.* (Under the care of R. M. Craven, Esq.) Robert Park, aged 11, was admitted on April 20th, 1859, having fallen into the hold of a vessel from a height of about fourteen feet. There were great contusion and swelling of the right temporal and orbital regions, completely closing the right eye. The pupil of the left eye was a little dilated, but sensible to stimulus. There was a doubtful feeling of depressed bone in the right temporal region; also twitching of the muscles of the left side of the face and mouth; and hæmorrhage from the nose, but not from the ears. He was sensible to external impressions, but could not answer questions. There was also a dislocation of the acromial end of the right clavicle. The head was shaved, and cold was applied.

April 21st. He had a good night. He is quite sensible, and speaks when addressed. He was ordered to take a grain of calomel and a saline effervescing draught every three hours, and to have low diet.

April 23rd. There has been no action of the bowels. He complains of pain in the head at times. There is now no convulsive movement of the muscles of the face. A drop of croton oil was placed on the tongue, which procured several copious evacuations. The clavicle was bound down with a pad and bandage; but some difficulty was found in keeping it in position.

℞ Mist. salinæ simplicis ℥viij; magnes. sulphatis ℥vj. Fiat mistura cujus sumat ℥i 4tis horis.

April 6th. When he attempts to whistle, his mouth is drawn a little to the left side; and his tongue also protrudes somewhat to the left. He was ordered to continue his low diet and aperient mixture.

May 6th. He has improved greatly. The tongue is now protruded in a straight line, and there is no paralysis of the muscles of the face apparent. All swelling of the scalp has subsided, and there is seen and felt an evident ridge of bone running horizontally along the right temporal region. Pressure on this part does not cause pain; nor does he complain at all of headache. He was allowed to sit up a little, and to have a small portion of meat for dinner.

May 14th. His friends took him away to-day, though strongly advised to let him remain for a time longer.

Case IV. *Compound Fracture of the Skull: No Cerebral Symptoms; Recovery.* (Under the care of W. J. Lunn, M.D.) Marmaduke Plaxton, aged 12, a stout lad, was admitted on June 13th, 1859, having fallen on his head into the hold of a vessel. There was a horizontal scalp-wound, three inches long, running along the right frontal and temporal regions.

The bone beneath was fractured horizontally, and the upper part depressed to a considerable extent. There were no cerebral symptoms of any kind. Cold water dressing was applied to the wound.

June 14th. He had a very fair night, and continued well during the day; but towards evening a very troublesome cough came on, with pain in his side. The tongue was foul; the bowels were confined; and the pulse was frequent. He was ordered to have an aperient draught immediately.

℞ Mist. salinæ simpl. ℥viij; antim. potassio-tartratis gr. j. Fiat mistura cujus capiat ℥i 4tis horis.

June 18th. The bowels have been well relieved. There is some strabismus of the right eye; but this, on inquiry, is ascertained to be natural to him.

June 28th. Since last report, he has gone on without a single bad symptom. The wound is suppurating. He was allowed a rather more liberal diet.

He was discharged cured about the end of July, having previously been made an out-patient for a week or two.

Case v. *Concussion of the Brain: Great Maniacal Excitement: Recovery.* (Under the care of K. King, M.D.) Richard Wright, aged 44, married, was admitted on November 19th, 1859, at 8 P.M., having fallen into the hold of a vessel, a distance of twelve feet, being at the time in a state of intoxication, to which he was addicted. There was merely a slight wound of the integuments over the right eyebrow. He was insensible, but moved the extremities when pinched or otherwise irritated; feet cold. The pupils were dilated, but not perfectly motionless. Pulse 88, full; respiration, 24 per minute, not stertorous. The head was ordered to be shaved, and an evaporating lotion constantly applied.

Nov. 20th. He passed a quiet night. The bowels were not open.

℞ Calomel. gr. v; olei crotonis ♏iij. M. Fiat pilula statim sumenda.

Nov. 22nd. The pupils continue dilated, though not so much so. The bowels have been well relieved.

℞ Calomel. gr. ij; pulveris opii gr. ¼. M. Fiat pilula 3tiis horis sumenda.

The head was ordered to be shaved, and a large blister applied to it.

Nov. 24th. He is beginning now to be rather restless, frequently getting out of bed. The pupils are now contracted.

Nov. 25th. He is very violent indeed, and will not lie quiet a minute.

℞ Vini antimon. potassio-tart. ℥i; aquæ ad ℥viij. M. Fiat mistura cujus capiat ℥i 2nda quâqua horâ.

Six leeches were ordered to be applied to each temple.

Nov. 26th. The leeches seem to have had a good effect, as he is quieter this morning. A blister was ordered to be applied to the nape of the neck.

Vespere. He is so violent that it is necessary to restrain him with a strait waistcoat.

℞ Solutionis morphiæ hydrochloratis ℥iij; vini antimonii potassio-tartratis ℥ss; aquæ camph. ad ℥viij. M. Fiat mistura cujus capiat ℥i tertiis horis.

Nov. 28th He has been a little quieter the last two days. He frequently gets out of bed to pass urine.

℞ Spiritûs ætheris nitr. ℥iij; tincturæ hyoscyami ℥iij; aquæ camphoræ ad ℥viij. M. Fiat mistura cujus capiat ℥i 4tis horis.

He takes also the following at night:—

℞ Sol. morph. mur. ℥iij; aquæ ad ℥viij. Fiat mistura cujus capiat ℥i pro dosi.

Dec. 3rd. He has been much quieter the last few days. He passes urine less frequently. He has meat daily, but complains of not having enough. He speaks sharply and abruptly, and has rather a wild look.

Dec. 4th. *Vespere.* He is very violent again to-night, restless, and talkative, requiring the use of mechanical restraint. A blister was again applied to the nape of the neck.

℞ Antimon. potassio-tartrat. gr. ij; potassiæ bicarb. ℥ij; tincturæ hyoscyami ℥iij; mist. camph. ad ℥viij. M. Fiat mistura cujus capiat ℥i 3tiis vel 4tis horis.

Dec. 11th. His medicine has never produced nausea or vomiting. He is very quiet now, and sleeps well, but talks a great deal, sitting up in bed, and looking very wild.

Dec. 14th. He is up all day now, and is much more tractable and obedient; but he still has a look of vacancy in his countenance.

Dec. 20th. He was taken away to-day by his friends. Some time afterwards, he was met in the street coming home from his work, when he appeared, and said he felt quite well.

Original Communications.

A CASE IN WHICH, AS A RESULT OF INJURY, THE WHOLE OF THE IRIS WAS FOLDED BACK AND BECAME INVISIBLE.

By J. Vose Solomon, F.R.C.S., Surgeon to the Birmingham and Midland Counties Eye Infirmary.

In the Association Medical Journal for the year 1855, at page 416, I recorded four cases in which, in consequence of a violent contusion of the globe, the iris became invisible. In one of these instances, the sclerotic was ruptured; in another, the cornea; in two, the sight was preserved. At the time when the cases came under my observation, the ophthalmoscope had not been introduced into England, and therefore I was unable to afford information respecting the appearances presented by the interior of the eye when illuminated by artificial light, and examined by means of a perforated mirror. I am gratified to be now in a position to supply this information, and to complete an account of a class of cases which are no less curious than rare.

Case. A bricklayer, aged 50, came under my care at the Birmingham Eye Infirmary on July 29th, 1859. He stated that he had been struck on the right eye ten days previously by an iron scraper, which blinded him. The external tunics were now inflamed; not a vestige of iris was to be seen; the aqueous humour was not clouded by effused blood. The patient complained of severe ocular and circumorbital aching pains. It was not deemed prudent to examine the internal structures by the aid of the ophthalmoscope until the 5th of August, the seventh day of the treatment. At that date, the light from the lamp did not penetrate through the turbid vitreous humour; the only object which was revealed was a mass of blood, of an irregular spindle shape, which would measure about four lines long, and a line at its widest part.

Aug. 9th. The patient's mouth was sore from the mercury which had been prescribed on his admission. The external tunics of the eye were less vascular. *Ophthalmoscopic Examination.* No iris nor lens was visible; the vitreous body contained blood-clots; the fundus had a pale yellow aspect.

On the eighteenth day of the treatment and the twenty-eighth of the accident, the patient could see my face, and with difficulty count my fingers; but he could not tell whether it was the back or the front of them that was placed before him. The sclerotic, near to its corneal epiphysis, was becoming flat, and formed a sort of neck, upon which was set the cornea. At the upper and inner side of this neck, and at about half a line from the margin of the cornea, was observed a dark line. Was this a fracture, or only a thinning of the sclerotic? This dark line was noticed a week later (Aug. 23rd) to be extending downwards. If anything, the sight was better.

August 26th. The neck at the inner and lower side of the sclerotic was more marked; and the globe was here flattened. The black line yielded readily to the pressure of a probe—indeed, to such an extent as to impress me with the belief that the fibrous membrane was wanting at this part. With a No. 6 cataract-glass, the patient distinguished one person's features from another's.

It was not until the 30th of August that the pain in the eye was reported to be "slight and occasional". He had hitherto suffered much from tensive pain in the globe.

Dec. 20th (fifth month of the accident). *Ophthalmoscopic Examination.* The vitreous contained what appeared to be numerous particles of pigment (*quere*, blood?), which resembled in density "wine-crust". They were smaller in size and fewer in number than they had been at the previous examinations. With the assistance of a cataract-glass, he saw my face distinctly. The black line in the sclerotic was much lessened in length; the rent was evidently undergoing a slow process of repair.

Feb. 1860. *Ophthalmoscopic Examination.* A cloud of fine muscæ lay deeply at the back of the eye, and rose slowly in a crescentic form when the globe was abruptly moved. There was to day some trace of the central artery of the retina and its vein. The choroid continued to be pale. The patient, with the assistance of a cataract-glass, read large type.

Remarks. Some difference of opinion exists among ophthal-

mic surgeons respecting the position taken up by the iris when rendered invisible from causes similar to that related above. A recent writer believes that the injury occasions the iris and lens to leap clean out of the eye, through a rent in the sclerotic. Without denying the possibility of such an occurrence, I am more disposed to seek an explanation of the phenomenon by a reference to cases where a part only of the iris disappears, as it must be evident that what happens to a part of the membrane may occur to the whole. I have observed that, if the iris be lacerated in its transverse diameter in two or more places, the whole of the segment included in the injury will in the course of a few days atrophy and cease to be apparent, although the aqueous humour shall be pellucid. Again, if the ciliary nerves be divided by a punctured wound of the sclerotic, so much of the iris as the nerves supply will collapse, so that the pupil is there extended to the rim of the cornea. Thirdly, if, in a cataract operation by extraction, the vitreous body becomes dislocated in front of the iris, and is allowed to remain there without interference, that part of the iris which is in proximity with the section atrophies, disappears, and in time loses its characteristic structure, being converted into a fibrous band. Moreover, dissection has proved that the greater part of the iris may entirely escape an external examination, and yet be found within the globe. In the *Archiv für Ophthalmologie*, b. i, p. 119, Von Ammon gives the details of an examination after death of an eye, in which the major part of the iris was rendered invisible by the concussion from a musket, which was loaded with water instead of lead, and discharged into the mouth, by a young soldier who had determined on committing suicide. The only visible portion of iris in the right eye was a crescentic fragment towards the external side. The point where this portion disappeared was neither torn nor abruptly folded inwards, but disappeared without its being possible to discern what had become of it; dissection showed that the upper, inner, and lower borders of the iris were pushed back. The vitreous body was displaced; the lens, with its capsule, touched the upper border of the middle of the superior ciliary processes, whilst the inferior border was found near the centre of the abnormally large pupil. The lens and vitreous body had displaced the iris. When the lens and vitreous body were removed under water, the iris slowly returned to its position.

Reviews and Notices.

On the Diseases, Injuries, and Malformations of the Rectum and Anus; with Remarks on Habitual Constipation. By T. J. Ashton. Third edition. London: Churchill. 1860.

This volume, which treats of some of the most troublesome complaints to which the flesh is heir, is so well known, that it needs no commendation at our hands. That it has reached a third edition, is the best proof of the estimation in which it is held by the profession. The new edition before us has been carefully revised, and very much improved by the addition of woodcuts, by Bagg, of the appearances presented by the various diseases.

London and Provincial Medical Directory, 1860. London: Churchill. 1860.

This work is a singular example of the advantage an independent editor has over one confined to an official form. It was supposed that the publication of the *Medical Register* would have the effect of materially crippling the work before us, if not of finally extinguishing it. The very reverse, however, is the real result; for the editors tell us that their sale last year was increased rather than diminished. The advantage possessed by the official *Register* is, of course, its greater accuracy; but this very accuracy only tends to the improvement of the *Medical Directory*, as it serves to correct its errors. In other respects, the *Medical Directory* has advantages peculiarly its own. It is, in fact, an autobiography of the whole profession; and, by reading the little histories each man writes of his own career, we can judge pretty accurately of his calibre, scientific attainments, and even of his disposition. The immense mass of interesting matter it contains connected with the profession, renders this annual volume really indispensable to the medical man's consulting table.

On the Medical History and Treatment of Diseases of the Teeth and the Adjacent Structures; being Lectures delivered before the Members of the College of Dentists of England in the Session 1858-9. By Benjamin Ward Richardson, M.A., M.D., Member of the Royal College of Physicians; Senior Physician to the Royal Infirmary for Diseases of the Chest, etc. Pp. 274. London: Baillière. 1860.

These Lectures are twelve in number, and embrace the following subjects:—1. The Constitutional and General Causes of some Diseases of the Teeth and the Adjacent Structures; 2. The Hæmorrhagic Diathesis in its bearings on Dental Practice; 3. Neuralgia in Relation to Toothache and Diseases of the Teeth; 4. Hysteria and Allied Conditions in Relation to some forms of Dental Affection; 5. Dyspepsia, Rheumatism, and Gout, in their Relations to some Abnormal States of the Teeth and Neighbouring Organs; 6. Diseases of Infancy and Childhood, as dependent on and as influencing Dentition; 7. Purulent Affections of the Gums and Adjacent Structures; 8. Malignant Diseases involving the Organs of Mastication; 9. Diseases of the Teeth and Maxillary Bones, arising from the Effects of Mercury, Phosphorus, Lead, and other Poisons; 10. Diet and Modes of Life in their Influence on the Organs of Mastication; 11. Chloroform and the Narcotic Remedial Series; 12. Pathological and General History of Necrosis, Exostosis, and Caries.

In the first lecture, Dr. Richardson passes in review the effects of various poisons on the dental structures, and concludes with the following propositions, as expressing in a few words the relationships which exist between constitutional causes and dental diseases.

"1. Dental diseases of whatever kind have two sources: a simple local source, and a constitutional source. 2. The diseases of the organs of mastication, arising purely from local causes, are limited in number; including caries, necrosis, inflammation or its upshot, and the ache consequent upon exposure of nerve. 3. Every form of tooth-disease may directly or indirectly originate in constitutional disorder, and some originate in no other ways. 4. In all such cases the true cause of the disease is external, and the system is merely the medium by which the cause passes, or through which it is carried to the locally diseased structure. 5. The causes acting on the teeth to produce diseases through the system, are of two kinds—chemical, as by introduction of poison into the body—and physiological, as by perversion of normal acts. 6. The inorganic poisons which through the system seem mostly to affect the teeth and adjacent parts, are mercury, the alkalies, and, perhaps, the malaria; the organic are the poisons of syphilis and small-pox. 7. *Mercury* produces caries, suppuration, and hæmorrhage from the gums; *syphilis*, atrophy and tendency to caries; *small-pox*, suppuration, alveolar exfoliation and dental necrosis; and *malarial poison* intermittent tooth-neuralgia. 8. Amongst the diatheses or dispositions of body affecting the teeth, the strumous, the dyspeptic, the gouty, the rheumatic, the cancerous, and the hæmorrhagic, are the most important. 9. The *strumous* diathesis, while it favours the development of all diseases of degenerative type, is not *per se—i.e.*, like syphilis or small-pox—a constitutional cause of dental disease. *Simple dyspepsia* is not a true constitutional cause. *Gout* is a true constitutional cause, leading both to acute ache and organic mischief; and *rheumatism* is a constitutional cause, giving rise to a specific rheumatic neuralgia of the tooth-nerve and to a specific periostitis. That there may be other forms of constitutional disorder arising from external causes, by which dental diseases are originated and intensified, is possible and probable." (Pp. 23-5.)

In the second lecture, the author enters fully into the nature and causes of the hæmorrhagic diathesis, and gives directions for its treatment when the teeth are concerned. For the local treatment of hæmorrhage from tooth-extraction,

he lays particular stress on the employment of a good styptic, a good plug, and the means of employing firm pressure.

"For stopping the hæmorrhage from a tooth, a chemical styptic is the best; and, taking it all in all, the nitric acid is on the blood of all animals the styptic most powerful. This acid, in extreme cases, may be applied on a pledget of lint direct to the bleeding vessel. I should really waste your time were I to enumerate the virtues of other styptics, for this combines the styptic properties of them all in the highest degree, and has no disadvantages as far as I know.

"As regards the plug. If the extracted tooth is at hand, and the fangs are unbroken, I think that the suggestion of Mr. Archibald Blacklock is the best, if it can be conveniently done; that, viz., of reinserting this extracted member. But I should suggest that before doing so the cavity of the tooth, emptied of its contained blood, should be injected with a weak solution of nitric acid. If the tooth cannot be used as a plug, and lint has to be applied, the lint should be used as it was in Mr. Davenport's case, and in the way that has been suggested by Professor Bell—viz., the lint should be applied, layer by layer, until the cavity is filled; the lower layers, or all of them being saturated in the styptic solution employed.

"Pressure must be continued; and a variety of means have been adopted for sustaining the direct force. Every advantage in this respect is, I think, secured by the simple and effective invention of Dr. Reid. In this instrument, a plate arranged so as to secure pressure between the jaw and some contiguous part, is fitted with a sliding screw, which can be adjusted to any cavity in the jaw, and can be made to exert pressure upon any plug. By a proper application of these simple local measures, coupled with general treatment, in the administration of the mineral acids or of lead, I cannot but believe that all cases of hæmorrhage are under control.

"There is another point, of a general kind, which must always be recalled. It is this: remember that hæmorrhage feeds, if I may use the expression, on itself. Remember that so long as hæmorrhage lasts, so long the resupply of fluid into the exhausted circulatory canals is derived from the watery matter of the tissues. On this remembrance base this line of practice; that whenever a patient leaves your hands, in whom tendency to hæmorrhage after extraction is obvious, you impress on him to inform you of the merest tendency to return of the flux. Patients are often ignorantly careless on this regard. They expect the hæmorrhage will stop, and that time will cure. You know that time will perpetuate, and you should instruct them to that effect." (Pp. 49-51.)

Passing over the third and fourth lectures, we meet in the fifth with some interesting observations on rheumatism and gout as affecting the teeth.

Acute rheumatism, Dr. Richardson observes, generally does not affect the muscles of the jaw or its articulation. Yet these parts do not always escape; and often, when they are attacked, the general manifestations of rheumatism are so deficient as to throw much doubt on the nature of the affection. In a case which came under the author's notice, there was a locked-jaw, with much pain, and some swelling on the cheek and about the ramus of the jaw. The diagnosis was further complicated by the fact that the man had injured his toe some weeks previously. The case might have been one either of hysterical trismus, of true trismus, or of rheumatism. The doubt was resolved, by the appearance of rheumatic swelling in the wrist and ankle, and, coincidently with these manifestations, the relaxation of the maxillary muscles. The case terminated as one of mild arthritic rheumatism; leaving, however, an impeded action of the jaw and of the organs of speech.

The characteristic symptoms of rheumatic inflammation of the alveolar periosteum are thus described:—

"The pain is dull, heavy, and yet severe. It is a steady pain; and it is a pain which conveys to the mind the idea of impression of the tooth. In inflammation of the dental pulp an opposite sensation is described; the tooth is spoken of as if it were bursting from its bonds: here it is gripped closer by its bony wall, and the patient is quite conscious of an alveolar cavity without any study of the skeleton. The pain is attended with febrile excitement, and often with heat and swelling of the gum. Eventually, some other indication of rheumatic mischief shows itself: some swelling of elbow, or knee, or wrist: and the diagnosis is confirmed." (P. 116.)

Dr. Richardson offers some instructive comments on the connection between gout and toothache and gout and neuralgia. Here is a case of gouty toothache related by the author.

"A man in the first period of the middle age, accustomed to good fare, late hours, and indoor life, was sitting at the wine table in the midst of friends and merriment. For some reason which was not very explainable to him, he took but little part in the mirth; he felt a drowsy low-spiritedness and a slight nausea. Then he had a singing sound in the ears, and some degree of pain in the ear. Suddenly the pain moved in position and increased in intensity. It moved to one particular tooth, and the agony was irrepressible. A strong man before, he was struck down now. He left his friends, and, unable to bear the torment, went to the nearest dentist for relief. The dentist he called on, a conscientious man, could find no tooth carious, and was opposed to extraction. But the patient, fixing on what he supposed the faulty tooth, insisted on removal, and a sound tooth was drawn. Strange to say, the extraction seemed to give relief, and a dose of physic completed the cure for the time. A few weeks afterwards, under circumstances almost identical, the same gentleman had a second seizure; but now the seizure, equally severe, was in the ball of the great toe. Quite unconscious of its meaning, this brief attack, for the pain subsided in a few minutes, passed without comment; but eventually another return of the pain in the toe ended in an outspoken and obstinate attack of gout. One day when I was visiting him, and talking to him about his symptoms, asking him, indeed, what premonitory signs had warned him of his diathesis, he cut me short with the question—'Doctor, did you ever see a gouty tooth?' I said, 'No, I think not.' 'Then,' said he, 'I'll show you one'; and forthwith he produced the molar, and gave to me its history as I have now recorded it.

"I would point out this class of cases to the junior dental practitioner with all the care I can bestow on it, because it belongs even more intimately to him than to the medical man. To the dentist the first application is made in such examples as I have here supplied, and the recollection of gouty odontalgia should not desert him. It shows at once the accomplished man, to make out a ready diagnosis in instances of this description; and really the diagnosis is not difficult. The circumstances under which the pain is elicited, the character of the pain, the accompanying dyspepsia, the free habit, the healthy tooth, and the inability of the patient to fix determinately on the aching member, are sure indications in the majority of cases of the disease which is presented for treatment.

"The neuralgia of gout, manifested over wide expanse of nerve distribution, is of equal interest, and presents nearly the same features as the gouty odontalgia. The neuralgia is local; it occurs suddenly; it alternates oftentimes with other gouty pains; it occurs in persons in whom the gouty diathesis is marked; it is produced by the indulgent habit which recognises not that 'enough is as good as a feast'; and as a general rule it ends ultimately in the institution of a regular fit of gouty disorder in the smaller joints." (Pp. 230-1.)

Further on in the book, in the last lecture, we find the connection of gout with the teeth again taken up, in regard to the occurrence of the typical gouty deposit in these organs. The author is speaking of the pathology of exostosis.

"In studying the pathology of exostosis, and especially of exostosis of the teeth, we must, to arrive at a correct history, glance not only at the microscopy, but at the chemistry of the subject. In examining some of the many specimens of exostosed teeth, which you in your kindness have laid before me, I observed that in two of them there existed between the fangs a softish, dry, earthy, whitish-yellow substance, which, closely connected with the tooth, was clearly not of the same structure. Filing down the fangs of these two and subjecting them to analysis, I precipitated from them crystalline bodies, which have the characteristics of uric acid, that acid which, as we have seen, is present in excess in gout, and forms with soda the gouty connection so often met with in the joints. Coupling this fact of the detection of uric acid in the way described above, with certain symptoms which mark, as I have thought, the origin of dental exostosis, I was led some time since to link the exostosis with the gouty diathesis. . . . . I have thus examined exostosed portions of sixty teeth, not individually, but in four divisions, so as to obtain sufficient quantity of matter for analytical inquiry. In one of these groups, crystals

of uric acid were distinctly yielded; in the remaining, there was no evidence whatever of the acid. The quantity of acid, moreover, supplied by one of the four groups (in which was included the pulverised mass of ten teeth) yielded less evidence of the acid than did the two teeth used in my first experiment. I am bound, therefore, to conclude that in the later observation, where the acid was found, it was yielded by an exceptional tooth, and that the deposit of the acid in combination with a base in, or, I had better say, upon an exostosed growth, is of rare occurrence, but so well marked, occasionally, as to leave no doubt of its existence." (Pp. 266-7.)

Both the medical and the dental professions will be gainers in knowledge by the publication of these *Lectures* of Dr. Richardson. To the former, it points out the fact that teeth are not merely set in their sockets like so many nails, to be pulled out when they become rusty, and replaced by new ones; but that they are, like every other part of man's body, liable to the action of a host of influences producing sometimes permanent, sometimes mere temporary derangement. How to know when an aching tooth should be pulled out, and when it should be left, is an important matter to the dentist. And not less so is it to medical men, to whose lot it frequently falls to perform the dentist's functions, but who, hitherto, have been rather left to the exercise of their common sense than guided by a clear and systematic exposition of the influences affecting the teeth, such as is found in the present volume.

Palæontology; or a Systematic Summary of Extinct Animals, and their Geological Relations. By Richard Owen, F.R.S., Superintendent of the Natural History Departments in the British Museum, Fullerian Professor of Physiology in the Royal Institution of Great Britain, etc. Pp. 420. Edinburgh: Adam and Charles Black. 1860.

Professor Owen has with great ability (as would be expected) filled up a chasm in our scientific literature; for, until the appearance of this work on *Palæontology*, we are not aware that any systematic arrangement had been made in this country of the fossil remains of the animal kingdom found in the strata of the earth's crust. This volume is a complete history of the various forms of animal beings which formerly, at different periods, tenanted the earth, arranged in the ascending order from the *protozoa*, or beings holding an intermediate position between the two organic kingdoms, up to the mammalia. Of the manner in which this task has been executed by Professor Owen, his already extensive reputation renders it unnecessary for us to speak. It must suffice merely to call the attention of our associates to the recent production of the work. Many among them, we believe, cultivate scientific matters beyond the immediate pale of their profession; and on such among them as feel an interest in the interesting and sublime science of geology, we would impress the necessity of allowing their minds to be enriched by the knowledge and the philosophical reasonings which Professor Owen offers to them.

Spectacles for Short-sighted Soldiers. A novel experiment, recommended by the Commander-in-Chief, has just been sanctioned by Government. Three infantry recruits lately arrived from England were at the usual medical examination found to be short-sighted, and in their present state useless as soldiers. The use of proper glasses, however, it was added, would make them instantly effective. The Director-General observed that if the Commander-in-Chief did not object to the incongruity of a soldier in the ranks wearing spectacles, there could be no other objection to their being supplied to such men as might require them. A large number of officers assist their sight in this way; and it is a well-known fact that many sportsmen wear glasses, some of whom are first-rate shots, and who could not see to shoot without them. Government have accordingly authorised the supply of suitable glasses to the men referred to, as an experimental measure, to be reported upon hereafter. (*Madras Times and Spectator.*)

Progress of Medical Science
AT HOME AND ABROAD.

MIDWIFERY AND DISEASES OF WOMEN.

THE DIAGNOSIS OF OVARIAN DROPSY.

An elaborate paper on this subject, from the pen of M. Boinet, has been published in the *Gazette Hebdomadaire de Médecine et de Chirurgie* for January 6th, February 3rd and 17th, and March 9th, of the present year. As the essay represents the opinions of a practitioner who is well known to have had large experience in the management of the disease in question, we subjoin a copious abstract; abridging little but the histories of some of the cases which he relates in support of his views.

The affections which are most commonly mistaken for ovarian cysts, are—ascites, pregnancy, extrauterine pregnancy, tympanitis, encysted dropsy of the peritoneum, fibrous and cancerous tumours, masses of indurated fæces, abscesses in the iliac fossæ, retro-uterine hæmatocele, hydatid cysts, etc.; and yet all these have only the appearance of ovarian cysts, and may be recognised by particular signs. But it is not enough merely to diagnose an ovarian cyst from any of the other abdominal tumours; it remains to be ascertained whether it is unilocular or multilocular, simple or compound; whether it is complicated with ascites, pregnancy, fibrous tumours, etc.; whether the contained fluid is serous and clear, or coloured, thick, thready, gelatinous, sero-purulent, etc.; whether the cysts are moveable or adherent. In its bearing on prognosis and treatment, the recognition of an ovarian tumour in any of the varied states in which it may present itself, is of the highest importance.

The characteristic signs of ovarian cysts differ, according to the nature of the cyst and its contents, and according to the presence or absence of complications. One of the first symptoms is a dull pain, a feeling of weight, a dragging, in one of the iliac regions. This feeling often arises from turgescence of the ovary, and is especially felt before or during the catamenial periods: at other times, the pain is only excited by pressure or by certain movements. These early symptoms, it is true, have no great diagnostic value at first; but at a later period, when the abdomen has become enlarged, and it has become impossible to discover by palpation on which side the cyst has arisen, then these symptoms become important, as indicating its point of origin.

Afterwards, when the disease has made some progress, there appears in one of the iliac regions a more or less painless tumour, readily felt by the hand, lobulated or round, and offering an equal elastic resistance. The tumour often passes the pubes and reaches the umbilicus before the patient has suspected its development; and then the medical man, called for the first time, ascertains with difficulty on which side it has commenced. At the end of a certain time, the abdomen acquires an uniform development and the size of an advanced pregnancy. If the patient is young and in the way of becoming pregnant, she is likely to deceive herself willingly; and it is only when the duration of the enlargement has exceeded the natural limits of gestation, when the abdominal tension increases, when a sensation of pain is felt, and when functional disturbance of the abdominal and thoracic viscera appear, that she recognises that she has a dropsy in spite of her generally good health.

There are special signs which characterise ovarian cysts at different periods of development. When the surgeon is called in at the commencement of the disease, particular attention should be given to the form of the abdomen. It will be often recognised, on careful examination, that it projects more on one side than on the other. If it appears uniform, palpation will in certain cases discover the presence of a tumour, the limits and origin of which may be ascertained. In young girls and in women who have never borne children, it is sometimes difficult to determine on which side the tumour has commenced; since, while it has been growing, the mass of the intestines has been pushed over to the other side, so that the abdomen is equally distended: in such cases, careful per-

cussion over every part of the abdomen discovers a tumour on one side and the intestines on the other. And, when the abdominal walls possess a certain degree of laxity as in women who have borne children, and the abdomen is not very voluminous, the tumour will change its position with the side on which the patient lies, and, in doing so, often causes a kind of undulation to be felt.

An ovarian tumour having been ascertained to exist, is it liquid or solid? Circumscribed pressure on the tumour, carried along the iliac fossa, will cause a more or less evident fluctuation to be recognised, and will cause an elastic depression to be perceived, which prevents the disease from being confounded with a fibrous tumour, impacted fæces, or any other solid swelling. Percussion gives a dull sound along the whole extent of the tumour; and fluctuation is often felt at the same time. Examination by the vagina or rectum proves nothing, so long as the tumour remains in the ilio-lumbar region, and is not yet developed in the pelvis; but when it has acquired a certain development, vaginal examination may be useful in ascertaining the side on which the tumour has originated, if this can be ascertained in no other way; for the tumour, in growing, carries the uterus with it, and gives this organ an oblique direction, so that the neck is turned to the opposite side from the fundus. This sign, important as it is, should not be had recourse to unless it is otherwise impossible to discover from which side the tumour has grown, and unless such discovery is of absolute importance.

At a still more advanced period, when the abdomen is uniformly enlarged, pressure and percussion must afford the diagnosis. By pressure are ascertained fluctuation inequalities, and points of hardness. If the abdominal walls are not too tense or œdematous, it is possible, by pressing in the abdomen at every point, to feel masses varying in extent, mobility, shape, and size, formed of more or less resisting tissue, sometimes hard, sometimes soft and elastic. These masses, which resemble spherical bodies somewhat flattened, are sometimes so large, so diversely placed, that they simulate displacement of the liver, spleen, or kidney. Sometimes the sense of fluctuation is only partial and indistinct, and the different parts of the tumour offer an unequal resistance. In these cases, there is either a multilocular cyst, or a cyst or tumour complicated with ascites. In other cases, fluctuation is general, and more evident than even in the highest degree of ascites.

Percussion is the principal and most certain means of recognising (which may be done in by far the greater number of cases) whether a cyst is unilocular or multilocular, multiple or complicated; whether the liquid it contains is serous, thick, thready, or gelatinous; whether the tumour has several lobes, and what is their size, and to what extent they correspond with the abdominal walls. The progress of the disease, the more or less severe pains which the patient has experienced, the more or less evident signs of inflammation which have appeared on the abdomen, the state of the general health, will also aid in pointing out the nature of the fluid, whether purulent or sero-purulent, etc.; and palpation will discover the presence of tumours, of greater or less hardship, which may complicate the cysts.

After these general considerations on the diagnosis of ovarian dropsy, the special characters of each variety of cyst remain to be described.

Simple cysts, when they have occupied the whole abdomen, and the distension is uniform, present the following symptoms.

The abdomen is projecting, so that one would say that the patient had arrived at the last stage of pregnancy. If, on percussing gently with one or several fingers, or, still better, on giving a slight fillip on any one point of the abdomen, the impulse of the fluid is plainly felt by the other hand, the cyst is unilocular if, in addition, percussion gives a dull sound in all the anterior and inferior parts of the cyst, and resonance only at the epigastrium and in the flanks on lower and lateral parts of the abdomen, whatever be the position of the patient. This occurs because the intestines, pushed aside by the tumour, project only beyond the edges of the cyst. Whether the patient is caused to lie either on the right or on the left side, the dulness is never displaced, but is always found at the same points and in the most elevated part of the cyst. These signs are constant, and enable an unilocular ovarian cyst to be distinguished from ascites, for instance. Another circumstance that may aid in the diagnosis is the generally good state of the health, and the rarity of swelling or œdema of the lower limbs.

In one case only of unilocular cyst has M. Boinet observed these diagnostic signs to fail. The case was one, which he observed with M. Putel, of a woman aged 60, in whom percussion denoted the presence of a serous fluid, and fluctuation was so distinct that the case might have been supposed to be one of ascites, if other signs had not denoted the presence of ovarian dropsy. A trocar was introduced; but no fluid escaped. On introducing a thread of iron wire through the cannula, a thick gelatinous mass was drawn out. Nothing in this case led to a suspicion of the nature of the tumour, for percussion constantly gave the same results; the only circumstance which could have, under other conditions, thrown any doubt on the diagnosis, was that the patient was much emaciated, had a dry yellowish skin, and showed traces of the cancerous cachexia; all the functions, besides, were tolerably well performed, except that the breathing was impeded. Examples of this variety of cyst are very rare.

When the abdomen has acquired a large size, it is sometimes difficult to ascertain on which side the cyst has arisen. In this case, recourse must be had to the history of the previous symptoms, and, as a last resource, to a vaginal examination.

Although the diagnosis of unilocular ovarian cysts appears easy, errors of diagnosis are often committed. A patient came to M. Boinet, telling him that she had an ovarian tumour, of the nature of which she had already been informed by two hospital physicians. M. Boinet, relying on their diagnosis, drew off a large quantity of serous fluid, and proceeded to inject iodine, according to the plan which he strongly advocates; but the patient at once uttered so loud a cry, that it was evident that the injection had been made into the peritoneal cavity. Purulent peritonitis set in; the pus was evacuated, and iodine was again injected several times; and the patient recovered, and was in good health in 1859, six years after the operation. M. Boinet observes, that the severe pain at the moment of injection is a certain sign that the peritoneum has been injected instead of an ovarian cyst.

M. Boinet is aware of numerous cases of error of diagnosis between ascites and ovarian dropsy. For instance, a young girl, on whom he operated with MM. Danyau and Fontès, had already been treated for ascites in the Hôtel-Dieu. Another case occurred in the person of a Norman lady, who had been tapped four or five times for ascites. M. Boinet threw in iodine injections, with the result of obtaining a radical cure.

Proceeding to speak of the diagnosis of the forms of ovarian cyst, M. Boinet relates the case of a lady aged 27, in whom M. Gendrin diagnosed the presence of an agglomeration of cysts, and advised merely palliative treatment; M. Boinet believed that there was an unilocular cyst of the left ovary, containing a thickish fluid, slightly thready, and probably of a chocolate colour; M. Velpeau diagnosed a cyst with thick walls, probably single; and M. Trousseau was of opinion that it was a simple unilocular cyst. It was finally determined to inject iodine, which was done by MM. Boinet and Bougoin. The cyst was unilocular, with very thin walls; it contained five *litres* of slightly thready chocolate-coloured fluid. The injection was repeated three times; and the patient recovered.

When the impulse of the fluid is not felt at all the points of a cyst, wherever percussion may be made, it may be said with certainty that the cyst is multilocular, or that the fluid which it contains is very thick. In these cases, the fluctuation is limited to the points in which the surface of each lobe corresponds with the abdominal walls. By a careful examination, it may thus be possible to count the lobes of which the cyst is composed—at least, the superficial ones: there is almost always a principal lobe, a mother-cyst, round which all the others are grouped. Occasionally the cysts are divided into several pouches by more or less apparent projections or depressions, which may sometimes be felt through the abdominal walls. The presence of tumours in the walls of the cyst, excessive thickness of the walls, division into several cells, and especially density of the contained fluid, all obscure undulation. Extreme distension of the cysts with a thick liquid gives a remarkable sensation of vibration. In these cases, percussion is not enough; careful palpation in all directions must be employed. In cases of multilocular cysts, the general health is ordinarily not very good.

It remains to determine the nature of the fluid contained in the cyst, and its density. When it is serous and limpid, so as to be capable of flowing readily through the cannula like water, fluctuation is free, easy, perceived at all points, resembling that of a considerable ascites. If the liquid is dense, thick, thready, glutinous, oily, fluctuation, although perceptible, is much less free. In cases where the liquid is too thick to give rise to fluctuation in the ordinary way, it may be felt by apply-

ing the two hands on the abdomen, and applying a to-and-fro motion, which will enable the fact to be discovered, that the liquid possesses a certain consistence.

If the patients experience or have experienced continued pains in the abdomen, if signs of inflammation have been present, if the abdomen has been or is slightly tender on pressure, the fluid, whether the cyst be single or multilocular, will probably be more or less coloured—reddish, sero-sanguinolent, coffee or chocolate coloured, etc. Multilocular cysts especially, where the fluid is thick, glutinous, and unhealthy, present these varieties of colour. It may with equal probability be announced that the fluid is purulent when the patients have a continued slow fever, loss of appetite, vomiting, diarrhœa, emaciation, pains in the abdomen and especially in the cyst—in a word, the symptoms of hectic fever, or those which indicate the presence of purulent deposits.

To avoid confounding ascites with encysted dropsy—the mistake which is most commonly made—it is sufficient to remember that the course of ascites is generally more rapid, that the enlargement of the abdomen is more uniform; and that, in ovarian dropsy, the abdomen is more protuberant, and preserves the same rotundity on whatever side the patient may lie. But percussion affords the surest means of diagnosis: in ovarian dropsy, it gives dulness in all the anterior, superior, and inferior parts of the abdomen, and resonance in the flanks; while, if the abdomen is resonant above and dull at the sides, there is ascites; the intestines floating to the surface of the fluid, while in ovarian dropsy they are pushed aside by the cyst. In ascites, if the patient is caused to lie on either side, the fluid changes its position, and resonance can always be detected on the side opposite to that on which the patient lies: in ovarian dropsy, on whatever side the patient may lie, the dulness is always at the same point. Another sign which is rare in ovarian cysts, and almost constant in ascites, especially when the disease is of a certain duration, is the infiltration of the lower limbs, and the presence of organic disease of the liver, heart, and other viscera.

In encysted dropsy of the peritoneum, fluctuation is much more difficult to perceive. It is circumscribed and limited, and is never found except at the same points. The intestines lie below, and do not, as in ascites, occupy the most prominent part of the abdomen. In this form of disease (which M. Boinet has seen twice in males and once in a female), the liquid is either collected in a single cyst extending, it may be, from the xiphoid cartilage to the pubes, and from one hypochondrium to the other, or in several separate cysts placed very superficially. The phenomena of distension and fluctuation are manifested here as in ascites; but encysted dropsy always arises from peritonitis, is slow in its progress, forms a more projecting swelling than ascites, and produces less impediment to respiration and displacement of the intestines.

[*To be continued.*]

RETROVERSION OF THE UTERUS BY AN ABSCESS.

At the meeting of the New York Pathological Society on October 26, Dr. Bauer presented specimens consisting of the rectum, womb, bladder, and a portion of the small intestine, which were removed from a woman who had been in a delicate state of health for a long time; still she was able to get about and do her house-work. She suffered from trouble of the womb, to remedy which she applied to a physician who made a correct diagnosis, pronouncing it to be retroversion. An attempt was made by the physician to put the organ in place; the finger was introduced into the anus, another into the vagina, and the basis of the organ was tried to be raised. The operation was exceedingly painful, so much so, that she desired to be left alone, unrelieved. She went home and was attacked with a very violent peritonitis; the treatment which was instituted proved of no avail, and she died six weeks afterwards. On *post mortem* examination, an abscess was found immediately in front of the basis of the wound, which seemed to have pressed the organ constantly down. How long this collection of matter existed, could not be said, but from the great changes in the surrounding parts, it was inferred that it must have been a good while. The rectum was perforated, and pus was discharged in considerable quantity from it. This state of things showed itself during Dr. Bauer's treatment of the case, and the peculiar character of the stools led to a microscopical examination of the matter, when, by the presence of an amount of pus-globules, the existence of an abscess was clearly made out. The lower wall of this abscess was the posterior wall of the bladder, and the anterior wall of the uterus, the basis of the organ, and the anterior wall of the rectum. Above, the abscess was closed by the small intestines, which were closely and firmly agglutinated by plastic material—so firmly, indeed, that the patient was able to pass nothing but pus from the rectum, for the last four weeks of her life. All efforts to relieve her in this particular were fruitless.

LETTERS AND COMMUNICATIONS.

Letters or communications for the Journal should be addressed to Dr. Wynter, Coleherne Court, Old Brompton, S.W.

Letters regarding the business department of the Journal, and corrected proofs, should be sent to 37, Great Queen Street, Lincoln's Inn Fields, W.C.

British Medical Journal.

SATURDAY, APRIL 14th, 1860.

THE COLLEGE OF PHYSICIANS AND THE PROPOSED NEW LICENTIATES.

The passing of the Medical Reform Bill has been the commencement of an epoch of revolution, of reorganisation, of crystallisation, if we may so term it, of the members of the medical profession. It was fondly hoped that one of the first fruits of the awakening of the profession to its just rights would be a drawing together of the metropolitan Colleges of Physicians and Surgeons, and the settlement of a joint Examining Board, from which the future general practitioners of the kingdom should receive their license. Such an union of forces, and such an improved examination as they would doubtless have instituted, must have resulted in sending forth a very highly educated class of medical practitioners. But, alas! the thing was too good to be true—at least as far as the College of Surgeons was concerned; and the flirtations between Lincoln's Inn Fields and Pall Mall have come to an untimely end—the latter, in short, has been very shamefully jilted.

The College of Physicians has evidently made up its mind to cultivate the affection of that overwhelming class in our profession, that ministers with so much self-reliance to the medical wants of the community. Of old the College would not condescend to notice anything but the physician pure and simple. It has tasted the sweets of numbers, however; it has gathered under one wing all the graduates in the country, and now it is making ready to spread forth the other to include the general practitioners. Can it be that the Council, notwithstanding their protests against the manner in which the Edinburgh College of Physicians has executed their raid across the Border, are really envious of their success?—or is the real motive of their new move a simple desire to sit in the seat of the Apothecaries' Company?

But what title, our readers will ask, is the College about to confer upon gentlemen who, from the very nature of their position, must practise pharmacy? The new-fledged members of the College, who have just been hatched from their condition of British graduates, and are gathered together under one wing, would possibly object to the other wing collecting a new brood, gathered from less academical sources. But the College is fine at distinctions. Those gentlemen who have already been admitted under the temporary bye-law are called "members",

and of course style themselves "doctors". The proposed new class are to be termed licentiates (the old term), and are not to be allowed to assume the prefix to their names. The distinction is very nice, almost too nice for the public apprehension. Of course, every general practitioner would be eligible for election; but future practitioners would have to submit to an examination.

Now, the whole virtue of this new scheme will depend upon the nature of the examination to which the College of Physicians propose to submit the canditates for the honour of their license. Unless it be a higher and more comprehensive one than that at present in use by the Apothecaries' Company, the substitution of one licensing body for another would be only a mere substitution of the initials L.R.C.P. for those of L.A.C.—a dignified exchange, it is true, but one carrying no real honour or benefit to the community with it. But we cannot doubt that the College examination will be a great advance upon that of the Hall, excellent as it has been of late years. That the profession would be glad to get rid of the stigma of receiving one of its diplomas from a trading company, is most certain; and if the Council of the College of Physicians really intend to carry into effect the creation of a new class of licentiates, we see nothing to prevent their doing so, and thus of their own motion performing their half of the duty of testing the capabilities of the future general practitioners, irrespective of the sulky behaviour of the sister College. There can be no doubt that, if once the establishment in Pall Mall sets up its flag in opposition to the one in Water Lane, to the former the future practitioners will flock. It remains to be seen, however, if all these changes in the titles of the profession—nay, in the curriculum its future members would have to undergo—will be allowed to take place without the permission of the General Council. It certainly does appear to us that all our old landmarks have been removed too much at the will of colleges and corporations, and without the authority of that central power which we have elected to dominate over all our proceedings, and which, we believe, will act for the good of all, irrespective of vested rights or special interests.

THE DENTISTS AND THE MEDICAL PROFESSION.

The simple and straightforward question, put to the members of the medical profession by the Council of the College of Dentists, which we noticed in the Journal for March 17th, has received, in favour of the separate organisation of the dentists, a number of answers which has exceeded expectation. The *Dental Review* for the present month gives a list of names extending over twenty pages, and informs its readers that two thousand medical men have signed the paper. From an intimation, however, at the end of the list, that six hundred other names had been received which it was not then possible to print, and from the probability that replies have continued to flow in, we do not go beyond the mark in supposing that, by this time, three thousand medical men have testified their approval of the acts of the College of Dentists.

In glancing over the list, we find the names of numbers of the most honourable among the profession in this country—men who would not lightly throw away their opinions, or sign a document of the nature presented to them, unless they were thoroughly convinced of its justice. In the provincial list, for instance, we meet with the names of Dr. Barham of Truro, Mr. Bulley of Reading, Dr. Barnes of Carlisle, Dr. Bell of Grimsby, Mr. Bailey of Thetford, Sir James Bardsley of Manchester, Mr. Crompton of Manchester, Dr. Cookworthy of Plymouth, Sir H. Cooper of Hull, Dr. Cowan of Reading, Dr. Copeman of Norwich, Dr. Cowdell of Dorchester, Mr. Cartwright of Oswestry, Dr. Duncan of Liverpool, Mr. Griffith of Wrexham, Mr. J. R. Humphreys of Shrewsbury, Dr. Heygate of Derby, Messrs. William Hey and Samuel Hey of Leeds, Dr. Radclyffe Hall of Torquay, Dr. Bower Harrison of Manchester, Dr. Inman of Liverpool, Mr. Kendall of Lynn, Mr. Michael of Swansea, Dr. Morris of Spalding, Mr. George May of Reading, Mr. Nunneley of Leeds, Dr. Noble of Manchester, Mr. Paget of Leicester, Dr. Porter of Peterborough, Mr. Philbrick of Colchester, Mr. A. Prichard of Bristol, Mr. Rumsey of Cheltenham, Mr. Square of Plymouth, Dr. Shearman of Rotherham, Mr. Snow of Lincoln, Dr. Sandwith of Hull, Mr. Stedman of Guildford, Dr. Styrap of Shrewsbury, etc., etc.

Not only have the gentlemen applied to signed the paper sent to them, but in several instances they have exerted themselves successfully to obtain the signatures of their professional friends. Thus we are told that Mr. Carnley of Hull sent a protest signed by thirty practitioners of that borough; and that Dr. Cookworthy of Plymouth sent *en masse* the signatures of thirty-eight of his medical neighbours. In several cases, a large proportion, sometimes amounting to the majority, of the profession in a town have appended their names to the paper: thus there have been, from Bath and Bristol, 49 signatures; Cheltenham, 34; Liverpool, 57; Hull, 41; Manchester, 44; Birmingham, 15; Leeds, 24; Plymouth, 49.

It is rarely that such an unanimous feeling is exhibited on the part of the profession; and this feeling has been called forth entirely by the acts of the College of Surgeons. The distrust with which that corporation is now regarded has reached a pitch which it never before attained; and, in many instances, the respondents to the letter of the College of Dentists have, we learn from the *Dental Review*, expressed in warm terms the indignation and disgust which they feel towards their Alma Mater in Lincoln's Inn Fields. They have sorely experienced that this "gentle mother" of theirs is a very unnatural parent, and that she has set a gross example of matrimonial infidelity. Surely this expression of feeling on the part of individual members of the profession, taken in conjunction with the protests and memorials which are almost every week addressed to the Medical Council, point to the approach of a great and terrible day of reckoning for the Council of the College of Surgeons.

We rejoice in the results which have attended the movement on the part of the College of Dentists; and we hope sincerely that they will have another and a longer list to publish in the next month's issue of the *Dental Review*. In the meantime, we urge those of our associates—probably not many, as far as we can judge from the list—who have not already responded to the appeal of the dentists, to do so, and thereby shew to the world that the honour of our profession has better keepers than the Council of the Royal College of Surgeons of England.

THE WEEK.

A PUBLIC meeting on the subject of Poor-law medical reform was held on Thursday last, at the Freemasons' Tavern, under the chairmanship of Mr. Griffin. There were a number of Union medical officers, as well as other practitioners, and a very fair sprinkling of the student element. The proceedings throughout were marked by great unanimity; and the following resolutions were passed (except where otherwise specified) without dissent.

1. Moved by J. ROGERS, M.D. (Soho), seconded by J. MACKINLAY, M.D. (Isleworth), and carried with one dissentient voice only—

"That the following Petition be presented to the House of Commons in favour of the Bill now before Parliament, entitled, 'A Bill on the subject of Poor-law Medical Relief, with a view to improve the Position of the Medical Officers, and to secure more efficient Relief to the Poorer Classes'."

2. Moved by G. E. NICHOLAS, Esq. (Wandsworth), seconded by C. E. WELCH, Esq. (Bethnal Green), and carried with one dissentient voice—

"That the following memorial be presented to the Poor-law Board, praying them to support the Bill now before Parliament, entitled 'A Bill,' etc." (as above.)

3. Moved by R. H. WHITEMAN, Esq. (Putney), and seconded by R. GRIMBLY, Esq. (Banbury)—

"That it is the opinion of this meeting that all Poor-law Medical Officers who have not already petitioned the House of Commons in favour of Mr. Pigott's Bill should do so without loss of time, and use their best exertions to obtain the support of the ratepayers and medical profession in their respective localities."

4. Moved by R. H. WHITEMAN, Esq. (Putney), and seconded by Mr. MASON (Middlesex Hospital)—

"That the thanks of the meeting be given to Mr. Pigott, Mr. Scholefield, and Mr. Briscoe, the introducers of the Bill into Parliament; and that they be respectfully requested to use every means in their power to carry the Bill with the amendments suggested through the House."

5. Moved by G. POUND, Esq. (Odiham), and seconded by W. T. FOX, M.D. (Broughton)—

"That the thanks of the meeting be given to the Proprietors and Editors of the *Lancet*, BRITISH MEDICAL JOURNAL, *Medical Times and Gazette*, and *Medical Circular*, for the aid they have given the Poor-Law Medical Officers in the gratuitous insertion of an extensive correspondence on the Poor-Law Medical Relief, and for the series of leading articles they have written in aid of the cause of the much-oppressed Poor-Law Medical Officers."

6. Moved by C. KIDD, M.D., and seconded by W. T. FOX, M.D. (Broughton) and H. SUTHERIN, Esq. (London)—

"That the thanks of the meeting are due and are hereby given to the Students of the various Metropolitan Hospitals who have so readily come forward to assist the Poor-law Medical Officers in their arduous struggle to obtain an Act of Parliament 'For the better Regulation of Medical Relief to the Poorer Classes in England and Wales'."

The proceedings were concluded with a vote of thanks to Mr. Griffin, passed on the motion of G. Ross, Esq. (Farringdon Street), and seconded by James Cooper, Esq., of Cromer. The petition and the memorial referred to in the above resolutions were laid on the table, and received a large number of signatures. It is to be hoped that every effort will be made to support at least the general principles of Mr. Pigott's Bill. The union medical officers, it must be remembered, cannot "strike" in a body, as the London cabmen did some years ago. Common humanity to their patients prevents this from being even thought of, and binds them to their work. This consideration should afford an additional and powerful motive to every honest man to do his best in obtaining for them that measure of justice which their cause demands.

It will be remembered that for some time a struggle has been going on at the Bedford Infirmary relative to the right of the medical staff to take their seats at the weekly committee of the Board. The medical men with much spirit determined sometime since to resign in a body unless their just demands in this respect were granted, and sent in a notification to that effect. The question again came before the Board at the quarterly meeting of the Governors on Monday week, and eventually it was decided that the medical officers are to be annually appointed on the weekly committee. Thus, by unanimity and firmness, the medical men have triumphed, as they always will do. The result of the Bedford General Infirmary struggle will, we hope, give heart to all medical officers whose past claims to take their seats at board meetings have hitherto been rejected.

Association Intelligence.

BRANCH MEETINGS TO BE HELD.

NAME OF BRANCH.	PLACE OF MEETING.	DATE.
BIRMINGHAM AND MIDLAND COUNTIES. [Ordinary Meeting.]	Hen and Chickens Hotel, Birmingham.	Thursday, April 19th, 6 P.M.

ADMISSION OF MEMBERS, AND PAYMENT OF SUBSCRIPTIONS.

THE following are the Laws of the Association regarding the ADMISSION of MEMBERS, and the PAYMENT of their SUBSCRIPTIONS.

"*Admission of Members.* Any qualified medical practitioner, not disqualified by any bye-law, who shall be recommended as eligible by any *three* members, shall be admitted a member at any time by the Committee of Council, or by the Council of any Branch."

"*Subscriptions.* The subscription to the Association shall be One Guinea annually; and each member, on paying his subscription, shall be entitled to receive the publications of the Association for the current year. The subscription shall date from the 1st January in each year, and shall be considered as due unless notice of withdrawal be given in writing to the Secretary on or before the 25th of December previous.

"If any member's subscription remain unpaid twelve months after it shall have become due, the publications of the Society shall be withheld from such member until his arrears be paid.

"The name of no member shall remain on the books of the Association, whose arrears extend over three years; but the omission of the name from the list of members shall not be deemed, either in honour or equity, to relieve any member from his liability for the subscriptions due for the period during which he has availed himself of the privileges of membership."

Either of the following modes of payment may be adopted:—

1. Payment by Post-Office Order to the Treasurer (Sir C. Hastings, M.D., Worcester), or to the undersigned.

2. Payment to the Secretary of the Branch to which the member belongs.

3. Members can also make their payments through the publisher of the BRITISH MEDICAL JOURNAL, Mr. Thomas John Honeyman, 37, Great Queen Street, Lincoln's Inn Fields, W.C., by post-office order, payable at the Western Central District Office, High Holborn.

PHILIP H. WILLIAMS, M.D., *General Secretary.*

Worcester, March 1860.

Reports of Societies.

MEDICAL SOCIETY OF LONDON.

Monday, April 9th, 1860.

A. B. Garrod, M.D., F.R.S., President, in the Chair.

Artificial Milk. Mr. Bishop brought before the Society, at the request of a German practitioner, some preparations of cow's milk, to which certain salts had been added, in order to render it similar to human milk. A letter from the author was read, in which it was pointed out that it was necessary to add water to cow's milk on account of the excess of casein, and at the same time to increase the quantity of milk-sugar and saline matters.

The President asked whether the Society would think fit to appoint a committee to investigate the matter.

Dr. Routh and Mr. Clarke said there were precedents in the Society for the institution of committees of inquiry; but Mr. Clarke objected to taking any further steps till the actual composition of the substance should be known.

ON SOME OF THE DISADVANTAGES OF EMPLOYING FALLEN WOMEN AS WET-NURSES. BY C. H. F. ROUTH, M.D.

The adjourned discussion on Dr. Routh's paper was resumed.

Dr. W. R. Rogers said that it was very important that the subject should be discussed by medical men. He agreed with Mr. Acton that we should do all we could to aid those who need it; but we have also a duty to our patients and to society. Our patients require us to get substitutes when milk is required. He was sure that there were too many causes, besides fashionable unwillingness, to prevent the nursing of children: we are then driven either to find a good wet-nurse, or a substitute in good artificial milk. He had been several times placed in a position to require a wet-nurse in his own family. He had objections to employ persons of the class described by Dr. Routh; he knew also the difficulties of obtaining married women as nurses. He had also tried the plan of obtaining a healthy woman in the country, who might nurse two; but here, too, he found difficulties. At last, he had heard of a woman in the country who had lost her own child; he saw her, but found that she had secondary syphilis. He recognised all the objections noticed by Dr. Routh. When we consider the moral effects both on the nurses and the other servants, there are reasons why we should hesitate to introduce the class of fallen women into families. He had frequently been told by servants who were pregnant that "they were going out as wet-nurses." He did not see how the difficulties referred to by Dr. Routh could be overcome in London. He would deprecate employing fallen women; not because they are abandoned, but from the dangers of employing them. Dr. Routh had asked if it was not likely that their milk might have a bad moral effect on the child. He (Dr. Rogers) believed much in the influence of parents on children, both as to structure and intellectual development and morality. Many of the intellectual qualities, he believed, were especially derived from the mother: of this there were historical instances. But this was not the question; we must all admit the vast influence of both parents on the progeny; but the milk of a mother and that of a nurse must produce similar effects on the child. He did not know that, if the nurse was diseased, any effect would be produced on the milk beyond generally damaging it, as it is by mental emotions, etc.; the change being doubtless chemical. But he did not know how far we were to be led. He could not come to the conclusion that the mental peculiarities of the nurse could produce any material effect on the milk. The general growth of the child principally went on in the first year: but the brain continued to grow for years afterwards. Was it possible to bring forward any case in which the mental character of a child had been influenced by the milk? The moral feelings of the child were not developed for years afterwards; and were only influenced by the teaching, and by the ideas implanted in its brain during its growth. There were no data on which to arrive at the conclusions of Dr. Routh on this point.

Dr. Jephson said that every man in hospital practice must be aware of the large number of deaths of children in hospitals and dispensaries from improper feeding. We all know that the ancients believed in the effect of the milk on the child. The nurses of Tiberius and Caligula were persons of bad character.

Mr. J. F. Clarke said that the matter resolved itself into a physical and a moral question. As to the physical question, was the child injured by being nursed by a fallen woman? and was it possible to find a substitute? He could not accept any of the objections. The class of women generally chosen as wet-nurses were mostly healthy, and there were *à priori* reasons for supposing that they would be so. As to the moral doctrine, it was extraordinary to suppose that the milk could have an effect, except such effect as would be produced through the nutrition of the body, in the same way as the mind may in after years be affected by the quality of the food which nourishes the body. He held it to be the duty of the medical man to aid the fallen women in their attempts to save themselves from prostitution by seeking situations as wet-nurses. Then, to go into the question farther, there is the effect on the woman's own child. This is a serious matter. He had known a case in which a woman had been introduced into a family as a wet-nurse, and had become respectable: and he believed there were many instances of the kind. If we are to stand as medical men between the women and perdition, we should lean to the side of humanity. The women are unfortunate, but not necessarily prostitutes.

Dr. Chowne would speak on the moral bearings of the question. He was pleased to hear the remarks of Mr. Clarke. He could not look on fallen women as necessarily vicious; but he would pity and help them, on account of the villany practised on them. He would be sorry that the Society should oppose their employment. If we look at the matter, we shall find it a choice of evils throughout. Many persons applied to him for situations: and he always applied for a character, which was almost always given—except, of course, as to the particular point of failure. Then as to the question of a single or a married woman, each plan might have its evils. Dr. Routh had said that the master of the house was liable to go wrong with the nurse; he (Dr. Chowne) had known no instance of the kind. As to married women, he objected to separating husband and wife; for here was an inducement to the husband to prove unfaithful. Then as to the constitutional diseases, as syphilis, he believed that more freedom from disease would be found among young girls, than among married women who were obliged to put their children out to nurse. Probably not one Fellow of the Society would like to recommend an unhealthy nurse; we would certainly not recommend a woman who had extensive manifestations of syphilis; and in a minor case, we should still fear lest some amount of disease would be manifested in the child.

Dr. Hardinge said that all the wet-nurses he had known, as employed from among fallen women, had caused mischief in families. He had known instances where wet-nurses had again become pregnant, to qualify themselves for another situation of the same kind. In the case of a gentleman who had died under his care from the effects of drink, his drunkenness was attributed to his wet-nurse. The same woman had nursed another child, who had also manifested drunkenness.

Dr. Richardson would refer to the purely physiological question of the transmission of disease. If a person had syphilis or other constitutional disease, arising from organised poison, he believed that the disease could not be communicated through the milk *per se*. He had seen a woman who had severe erysipelas, and who had nursed her child throughout without communicating the disease. Poisonous secretions introduced into the stomach did not affect the milk. Granting, then, that there was no direct inoculation, he did not see how the disease could be communicated. He could not recognise the effect of the mind: for if it were so, we ought to have all kinds of mental aberration from different kinds of food. As to the moral question, he agreed with Dr. Rogers that the women should not be degraded; and that wet-nursing was not the employment to which to put these women. There were other occupations, as printing, watchmaking, etc., at which they might be employed. It is not necessary to employ wet-nurses; children had, indeed, died in the Foundling Hospital when brought up by hand, but it was from food on which they could not live.

Mr. Acton asked permission to read an extract from a work entitled *Woman's Thoughts upon Women*. Having read it, he said that he was happy to think that women themselves were beginning to take up the question. He did not support the fallen women as a class generally. But it was new to him to be told, that the unmarried women alone had bad characters, for many married women are little better; they often marry only to save their character. He asked what was meant by the expression of Dr. Routh, that by the employment of a wet-nurse, the death of her child was authorised. He knew that, if the woman does not go out as a nurse, she has often no means of

supporting herself, and the child dies. The occurrence of infanticide arises from the fact that the mothers have not the means of subsistence; and it was to prevent infanticide that he had recommended the employment of fallen women as wet-nurses.

Dr. Routh was behind no one in feelings of sympathy for fallen women, whom he regarded as often the victims of villany on the part of men. In many instances, it is the men and not the women who ought to be punished. Then, as to the want of option in London, he believed it altogether an error. We ought to be able to save the lives of numbers of children by proper food. It was possible to feed cows and goats in such a way as to assimilate their milk in composition to human milk. This had been practised in Ireland, and it was now practised in Malta and Switzerland. He did not maintain that the married women were perfectly pure. But some adopted the plan of having a married woman to feed the child in the morning and evening, the child being fed by hand in the interval; and this with success. As to the question of the moral influence, he had said that, analogically speaking, there was likely to be such influence. All would admit that the human body consists of soul and body; the former acts through the brain, which is material, and the nutrition of which must depend on the materials entering the blood. All would admit the transmission of family likenesses; and also the acquirement of likeness between husband and wife. He believed them to be connected with the development, possibly, of a peculiar cell-growth. His general experience was that, in many cases, the first children of the fallen women were not healthy. Then as to the question of saving the women from infamy, the argument most to the point was that urged by Dr. Richardson, of obtaining them other employment. As to the transmission or nontransmission of disease by the milk, he could not agree with Dr. Richardson. In answer to Mr. Acton, he maintained that, if we employ a woman as a wet-nurse, her child will almost certainly die; and we are not justified in placing the mother in such a position as shall authorise the death of a child. The mortality of illegitimate children was greatest in those districts where most wet-nurses were employed.

HARVEIAN SOCIETY OF LONDON.

Thursday, April 5th, 1860.

Henry Thompson, Esq., President, in the Chair.

Traumatic Phlebitis. Dr. Stewart related the particulars of a case of phlebitis of the femoral vein and rupture of the internal and middle coats of the femoral artery, resulting from a blow. The vein and artery were exhibited, as well as a drawing of the parts taken at the time of the *post mortem* examination.

The subject of the injury was a tall pale strumous girl, aged 12 years. Whilst at school, a fellow-scholar thrust a piece of stick up her clothes, and struck her violently on the groin whilst the leg was extended. The blow gave her much pain, and she felt very ill. The leg became stiff, and she walked home with difficulty. Except aperients, no medical appliances were adopted for two days, when Dr. Stewart was sent for her, and he found her feverish and very excitable. There was much pain along the course of the femoral vessels, the leg was swollen, and the skin of a dusky hue. The countenance was very anxious. Salines with antimony were ordered; and for two days she greatly improved; but on the third day, the governess of the school came to see her, and soon after an angry interview, the child sank and died. The *post mortem* examination shewed the femoral artery, as it emerged from beneath Poupart's ligament, distended; and upon slitting it up, the two inner coats were found torn. The femoral vein was injected and blocked up with fibrinous deposit. The heart was filled with black liquid blood. It was difficult to assign the immediate cause of death in this case—was it the escape into the heart of some of the fibrinous deposit from the vein; or was it simply the shock produced by the interview with the governess?

Mr. W. Adams, Dr. Camps, Dr. Pollock, Dr. Handfield Jones, Mr. Cleveland, Mr. Ballard, and the President, commented upon the case; and the general impression was that the escape of a fibrinous clot into the heart was not sufficient to account for death, as the blood in the heart was fluid; that there was great depression produced by the phlebitis; and that in that state fatal syncope was readily produced by mental annoyance.

Tapping in Empyema and Hydrothorax. Dr. Hamilton Roe mentioned a case of empyema occurring in a child twelve years old. The lungs were perfectly resonant, and there was no sign of tubercles. The heart was displaced to the right side. A small trocar having been passed into the pleura, a half pint of pus was withdrawn with perfect relief to the symptoms, and the child got quite well. In tapping the chest, Dr. Roe advised the use of a small trocar; and that, to prevent the admission of air into the pleura, the cannula should be withdrawn as soon as the fluid ceased to flow freely from the tube. In long standing cases of pleuritic effusion, tapping was useless, because the fluid would collect again; but in more recent cases, provided the inflammation had subsided, tapping cured the patient at once, without having recourse to the depressing agency of mercury. The effusion which was developed during active inflammation was curable by general treatment, and tapping was not called for.

Dr. Pollock urged the early performance of this operation, as adhesions prevented the return of the lung and heart to their normal positions. He had seen the air pass freely into the pleuritic cavity in a case operated on at the Consumption Hospital, yet the patient got well. He would not advise tapping whilst inflammation was going on, nor in cases of effusion resulting from tuberculosis; but in passive effusion, he thought the operation desirable. Slight effusion was cured by good diet. There was a class of cases not uncommonly met with in which there was crepitation above the water line, suggestive of tubercle, but which in fact depended on the pressure produced by the effused fluid. In these cases, tapping may be advantageously resorted to.

Dr. Hare had seen cases operated on which would have done well without operation. He had cured cases of pleuritic effusion by mild mercurial and other treatment in three weeks. In a case of empyema which he had seen tapped, fourteen ounces of fœtid pus were drawn off. The wound continued open, and there was a discharge for two or three years. The case occurred twelve years ago, and the patient was now well and in service.

Dr. Handfield Jones, Mr. Cleveland, Dr. Vinen, Mr. Weeden Cooke, Mr. Ballard, and Dr. Camps, joined in the discussion. It was urged that tonic treatment should not be forgotten in these cases; that iodide of potassium was a useful remedy; that the empyema mentioned by Dr. H. Roe was the exact counterpart of a cold abscess forming in any other part of the body; and that the operation of tapping was called for in double pleurisy, but might be avoided when one side only was affected.

Editor's Letter Box.

THE ASSOCIATION AND THE JOURNAL.

Letter from John Dix, Esq.

Sir,—Dr. Stewart would probably feel himself aggrieved if I allowed his letter to pass entirely without comment: silence might be construed into contempt.

I pray you, therefore, to present to him my most respectful compliments, and to assure him that I have derived more amusement from his witticisms than instruction from his statements. I ask him for arguments, and he answers me with "chaff": I ask him for reasons, and he replies to me with gibes: I ask for the grounds of his opinions—the foundations of his theories, and his response is, "I boldly *avow* my conviction." I do not blame him for this; for, if he has nothing better to say, how can he be expected to say it? *Ex nihilo nihil fit.* You can't get blood out of a flint, or make a silken purse of a sow's ear.

It may also interest him to know that I *did* recognise in his "exceedingly familiar, expressive, and much used quotation," a vapid and hackneyed vulgarism.

Judging of the bulk from the sample, of the banquet from the *morceaux*, of the feast from the tit-bits with which we were favoured, it is by no means "wonderful in the eyes of Mr. Dix" that Dr. Stewart's "remarks were, at his own request, very briefly reported in the Journal". On the contrary, Mr. Dix is of opinion that Dr. Stewart has thereby shown a just and proper appreciation of the merits of his own oration.

It will be time enough for Dr. Stewart to taunt me with being an "oracle", "a censor of the press", "a distinguished Mentor", "a high authority", etc., when I *assume to be such*—which is not yet; to carp at my logic when he finds me tripping therein—when, for instance, he finds me writing any-

thing so delightfully incoherent in reasoning as this:—"What would he (Mr. Dix) have done in such circumstances? I humbly put the question, but cannot pretend to answer it, not having yet attained that high position which makes weight a recommendation, and prolixity a grace of style." What this high position may be, is not very clear; but, supposing Dr. Stewart should ever attain to it, can he explain how it will enable him to divine "what Mr. Dix would have done" under any given circumstances?

Again: "*Convince* them (the associates) that their own organ is a favourite with the profession, and that their papers will be read and studied in its pages; and they will take a pride in being contributors. . . . I for one shall be happy to contribute, if the necessary funds are not forthcoming, towards the attainment of so desirable a consummation."

The *vis argenti* has no doubt ere this brought about conviction in more ways than one; but what are *the funds* here alluded to, which are to produce this *remarkable* revolution in the minds of the readers of the Journal? Peace! captious critic! Surely these are the funds of his *own wit and eloquence*, which Dr. Stewart will henceforth be "happy to contribute" to the adornment and improvement of the Journal.

I am, etc., John Dix.

Hull, April 3rd, 1860.

POOR-LAW MEDICAL REFORM.

Letter from W. Falshaw, M.D.

Sir,—The perusal of your leading article this day on Poor-law medical reform has afforded me the greatest pleasure, especially the important observations you have made on some of the clauses contained in Mr. Pigott's Bill now before the House of Commons.

Amongst others, you have made some judicious comments on Clause xxxviii, which I consider to be one of the most important in the whole Bill—important alike to the profession and to the public, and one, too, which I think is now imperatively demanded.

It is a strange anomaly that whilst in many countries—even in Scotland—the inquiry into the cause of death is conducted almost exclusively by medical men, in this country (at least, in this part of it), they seem to be studiously excluded from such investigations.

However, my object just now is to give a case which occurred here so recently as Sunday last, which will well illustrate the *many* benefits likely to accrue from the operation of Clause xxxviii, and strongly corroborate the important remarks you have made on that clause.

Richard Varlow, aged 24 years, was travelling from Colne, where he had been on a visit, to his own home in Rossendale. Arriving at the Ramsbottom station, it was necessary for him to change carriages; and, in trying to do so, he was supported by the bystanders, who saw that he was very ill. He had scarcely reached the platform when he died, apparently from exhaustion. He was in a state of extreme emaciation; and it was soon ascertained that he had been very ill for months previously, and that the cause of his death was phthisis pulmonalis. It was also stated that three or four members of the same family had died within the twelvemonth of the same disease. Much to the surprise of everybody, a coroner's inquest was held.

Now, if Clause xxxviii of Mr. Pigott's Bill had been in operation, the district medical officer would have made an inquiry into the cause of death, which would have been very satisfactory to the public, and especially so to the relatives of the deceased; and, what is of much importance, would probably have furnished the Registrar with a certificate of the *real cause of death;* and with this difference to the country, that, whilst the most satisfactory inquiry would cost but five shillings or thereabouts, the other would probably cost as many guineas. Nor is this the only benefit. The medical man would commence his inquiry *early*. In the above case, if not otherwise engaged, I see no reason why he should not have made an inquiry the same afternoon; and then the relatives could have taken the body home—a matter of no small importance. As it was, the inquest did not take place until Wednesday; so that three whole days elapsed before the body could be *recovered*. Had the young man died at his own house, even had he been found dead in his own house, there would have been no coroner's inquest; and the cause of death would have been correctly stated by his medical attendant. But his death occurring from home, the country is put to an unnecessary expense; the relatives to additional trouble and mental anxiety; and last, though not least, the Registrar-General is prevented from receiving a true return of the cause of death, and has probably to put up with such vague expressions as "Died from natural causes", or "Died by the visitation of God".

I am, etc., William Falshaw.

Ramsbottom, April 7th, 1860.

THE UNIVERSITY OF ST. ANDREWS' AND THE POOR-LAW BOARD.

Letter from G. E. Day, M.D.

Sir,—May I ask you to find room in your next number for the following extract of a letter which the University authorities have just received from the Assistant Secretary to the Poor-law Board?

"I am directed to state that the evidence now before the Board is sufficient to satisfy them that a person possessing a diploma from the University of St. Andrews' is legally qualified to practise medicine. To that extent, therefore, such persons will be eligible to hold the office of Poor-law medical officer, under the order of the Board dated the 10th December, 1859."

I am, etc., George E. Day, M.D.,
Professor of Medicine.

United College, St. Andrews, April 1860.

Medical News.

BIRTHS, MARRIAGES, DEATHS, AND APPOINTMENTS.

** In these lists, an asterisk is prefixed to the names of Members of the Association.*

BIRTHS.

Of sons, the wives of—

Finch, Robert, M.D., Blackheath, on April 3rd.

Molloy, R., M.D., Clarendon Villas, on April 6.

Park, Thomas, Esq., Surgeon Royal Artillery, at Stoke Damerell, on April 7.

Of daughters, the wives of—

Cobbold, T. S., M.D., Norland Square, on March 27.

Chapman, F., Esq., Surgeon, Richmond, on March 31.

Murchison, Chas., M.D., Sackville Street, on April 1. (Child survived only a few hours.)

MARRIAGES.

Blick, Charles, Esq., son of the late R. Blick, Esq., Surgeon, of Sutton Coldfield, to Harriet, eldest daughter of *George N. Swinson, Esq., of Leamington, on April 3.

Farr, Septimus B., Esq., Surgeon, of Hemel Hempstead, to Frances A., eldest daughter of George A. Smith, Esq., of Hemel Hempstead, on April 4.

DEATHS.

Abercrombie, John, Esq., late Surgeon 19th Light Dragoons, at 25, Kensington Square, aged 82, on April 3.

Atkinson, J. J., Esq., retired Surgeon Bombay Army, at Pinhoe, near Exeter, aged 44, on March 29.

*Collison, Robert, Esq., at Newport Pagnell, suddenly, aged 78, on April 3.

Cotton. On April 4th, at 46, Clarges Street, aged 6, Sarah, youngest child of Richard P. Cotton, M.D.

Edie, John, Esq., Surgeon, at Liverpool, on March 28.

Ellis. On April 6th, at 63, Sloane Street, aged 4, Florence Mary, daughter of Robert Ellis, Esq., Surgeon.

Fisher. On April 6th, at Cambridge, aged 30, Catherine M., wife of *William W. Fisher, M.D., Downing Professor of Medicine in the University.

FitzPatrick. On March 7th, at Bath, William J. W., eldest son of John FitzPatrick, M.D., Madras Army.

Guislain, Joseph, M.D., at Ghent, aged 63, on April 1. Dr. Guislain was one of the public inspectors of asylums in Belgium, and was well known for his contributions to psychological medicine.

Malden, Jonas, M.D., late of Worcester, aged 68, at Cheltenham, on March 31.

Perry, William D., M.D., at Everton, aged 63, on April 6.

Rowdon. On April 1st, aged 9 months, Katherine Agnes, infant daughter of Henry M. Rowdon, M.D., Nottingham Place, W.

SKEETE, Edward, M.D., on March 25.

SUGGATE. On March 26th, at Greenwich, aged 67, the widow of H. E. Suggate, Esq., Surgeon R.N.

SYMPSON. On March 27th, at Lincoln, aged 32, Caroline, wife of *Thomas Sympson, Esq.

APPOINTMENTS.

*SKINNER, Thomas, M.D., appointed one of the Honorary Medical Officers to the Northern Dispensary, Liverpool.

PASS LISTS.

ROYAL COLLEGE OF PHYSICIANS OF LONDON. At the Comitia Majora, held on Monday, April 2nd, the following gentleman, having undergone the necessary examination, was admitted a member of the College:—

DIXON, Frederick B., M.D., Hoxton

At the same Comitia, the following gentlemen, having been previously elected under the temporary by-laws (no longer in force), were also admitted members of the College:—

ARMSTRONG, A., M.D., Malta
DUIGAN, Daniel John, M.D., H.M.S. *Vulture*
LAIRD, Samuel, M.D., Douglas, Isle of Man
MACKAY, George, M.D., Royal Naval Hospital, Plymouth
MACKAY, Alexander E., M.D., H.M.S. *Royal Albert*
RAYNER, Edward, M.D., Paris

APOTHECARIES' HALL. LICENTIATES admitted on *Thursday, March 29th*, 1860:—

AXFORD, Charles J., Staunton
DAWSON, Frederick, Islington
DEAN, Thomas, Paddock, Huddersfield
EDGER, Wm., Polton, Barnstaple
HAWTHORN, H. J., Uttoxeter
HIND, Charles W., Swindon
PAINE, William, Topsham
ROBERTS, Carr H., Shaftesbury
RODGERS, F. J., Helston
SHORTO, J. R., Southampton
SUTTON, Henry G., Ilminster
THOMAS, Benjamin, Llanelly
WATKINS, Walter, Brecon

The following gentlemen also, on the same day, passed their first examination:—

BARTLEET, Thomas H., Birmingham
ELLIS, Edward, University College
HARVEY, Wm., Penzance
HUNTER, R. H., Tottenham
MAJOR, George A., Guy's Hospital
SMITH, Robert C., Manchester School
SUTTON, F. J., Ilminster
THOMPSON, H., Westerham

Thursday, April 5th.

ADAMS, Thomas R., Kilmoganny, Ireland
DRAKE, Thomas, Kingsclere
EGLES, Gabriel M., Barcombe, Lewes
FARRANT, Samuel, Collumpton
GODFRAY, Charles Le V., Jersey
GODWIN, C. H. Y., Winchester
GRAHAM, A. F., Liverpool
HARRIS, A. B., Mevagissey
HARRIS, Wm. J., Worthing
MANNING, Frederick N., Milton, Northampton
MARCH, Henry C., Newbury
MERRYWEATHER, Philip E. C., Sydney
MITCHELL, T. C., Bedford
MOCKRIDGE, John, Army
PONKER, George F., Henley-on-Thames
STILLWELL, James
WARBURTON, James P., Betley, Newcastle-under-Lyne
WISE, Wm. C., Plumstead
YOUNG, Edward P., Henley-on-Thames

The following gentlemen also, on the same day, passed their first examination:—

EVANS, D. N., Edinburgh
LEE, Herbert G., Manchester

THE ROYAL COLLEGE OF SURGEONS.

THE following memorial has been addressed to the Medical Council by the North Staffordshire Medical Registration Association:—

To the Members of the Medical Council of the United Kingdom.

GENTLEMEN,—Having heard with surprise and regret that the Council of the Royal College of Surgeons have admitted to examination and granted diplomas to persons who have in no way complied with their regulations laid down for the course of study and hospital attendance; and having also seen that the Royal College of Surgeons justify their proceedings by complaining of the highly penal clauses of the new Medical Act,

We, the North Staffordshire Medical Registration Association, beg to protest against such proceedings, on the following grounds:—

1. That this Society considers the new Medical Act to be a great boon and protection to the profession; that it has been obtained with great difficulty, and deserves the warmest support both from the profession and Royal College of Surgeons, whereas this act of the latter materially tends to neutralise its effects; and

2. That it greatly depreciates the value of the diplomas of the Royal College of Surgeons, which is in itself a great act of injustice to those already holding them, and tends to lower the honour and dignity of the profession.

This Society, therefore, earnestly entreats you to exercise the powers given you by the new Medical Act, to constrain the Royal College of Surgeons to act in accordance with the regulations laid down for the admission to the examination for the diploma of membership of the Royal College of Surgeons; as this Society considers the course they are adopting at present to be inconsistent with the dignity and interests of the profession.

SAM. MAYER TURNER, *Chairman.*
JAMES YATES, *Hon. Sec.*

Newcastle-under-Lyme, April 9, 1860.

The following memorial has also been issued by the Birmingham and Midland Counties Medical Registration Association:—

To the President and Members of the Medical Council.

We the undersigned, President, Vice-Presidents, and Committee of the Birmingham and Midland Counties Medical Registration Association, beg respectfully to call your immediate attention to a practice of the Council of the Royal College of Surgeons of England, of granting its diploma to persons who have not undergone the usual preliminary course of professional education.

Such irregular grants of diplomas have been not unfrequent of late; and examples of the exercise of such discretionary powers on the part of the Council of the College of Surgeons having come under our immediate notice, we thought it our duty to forward to the said Council a strong remonstrance upon the subject; and we received a reply, the purport of which was to justify the proceedings of the College of Surgeons, on the ground of "the stringency of the Medical Act".

This explanation appears to us (and we believe to the profession generally) as wholly unsatisfactory; for we are firmly and decidedly of opinion, that the recent course of action of the College of Surgeons, while it is extremely unjust towards the present members of that body, can neither conduce to the good of the public nor the dignity of the profession.

We believe these irregular grants of diplomas to be in direct contravention both of the letter and of the spirit of recent legislation; and considering as we do, that the members of the Medical Council are the proper guardians and exponents of the Medical Act, we are most anxious to elicit their opinion, at their earliest convenience, with reference to the question at issue between the College of Surgeons and (we may fairly say) the whole body of the profession.

BELL FLETCHER, M.D., *President.*
JOHN ANTHONY, M.D., Birmingham
THOMAS TAYLOR, Birmingham
EDWARD MOORE, Halesowen
} *Vice-Presidents.*

Committee—Saml. Berry (Birmingham); S. A. Bindley (Birmingham); John Carter (Edgbaston); Thos. P. Heslop, M.D. (Birmingham); W. Lees Underhill (Tipton); Edwin Chesshire (Birmingham); Oliver Pemberton (Birmingham); John Postgate (Birmingham); Walter C. Freer (Birmingham); George Yates (Birmingham); Charles Townsend (Birmingham); C. S. Meeke (Birmingham); John Warnock (Birmingham); G. R. Yelloly (Birmingham); K. C. R. Jordan (Birmingham).

SAMUEL SPRATLEY, *Hon. Sec.*

THE JACKSONIAN PRIZE. At a meeting of the Council of the Royal College of Surgeons, on the 12th instant, the Jacksonian Prize of Twenty Guineas was awarded to Mr. John Whitaker Hulke, F.R.C.S., assistant-surgeon to the King's College and Royal Ophthalmic Hospitals, for his essay on the morbid changes in the retina as seen in the eye of the living person, and after removal from the body, together with the symptoms associated with the several morbid conditions, illustrated by cases, drawings, and preparations. At the same time, an honorarium was awarded to Mr. Charles Bader, a member of the College, for his dissertation on the same subject.

HARVEIAN SOCIETY OF LONDON. On Thursday, April 19th, a paper will be read by Dr. Fuller, "On the successful Treatment of Hooping-Cough by Sulphate of Zinc and Belladonna."